

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Baltimore City Health Department				BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 03501	
BIRTH NO. 8-126 72 03501				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <u>Spicer Emily O.</u>				2. DATE AND HOUR OF DEATH <u>April 6, 1972</u> 12 M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <u>UNION MEMORIAL HOSPITAL</u>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE <u>MD</u> B. COUNTY <u>BALTO</u>		C. CITY OR TOWN <u>Baltimore</u>	
				D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		E. STREET AND NUMBER <u>1500 BARKER AVE. Towson MD</u>	
5. SEX <u>F</u>	6. RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>08-08-90</u>	9. AGE (In years last birthday) <u>81</u>	10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOME</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Housewife</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>CHARLES HOLMAN</u>				14. MOTHER'S MAIDEN NAME <u>LAURA DELLA</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service <u>No</u>		16. SOCIAL SECURITY NO. <u>213-03-0936-D</u>		17. INFORMANT <u>Mrs. J.B. HART</u> ADDRESS <u>15 E. BARKER AVE. Towson, MD.</u>			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <u>UPPER GASTRIC INTESTINAL BLEEDING</u>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION LAST <u>HASCUO</u>							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <u>HASCUO</u>							
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>NO</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>April 1</u> 19 <u>72</u> to <u>April 6</u> 19 <u>72</u> that (I) (we) last saw the deceased alive on <u>April 6</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>[Signature]</u> DEGREE				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>April 6 72</u>	
23C. PHYSICIAN'S NAME (Type) <u>TULLIO BERTORINI</u> DEGREE				23D. ADDRESS <u>UNION MEMORIAL HOSPITAL</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>4-10-72</u>		24C. NAME OF CEMETERY or CREMATORY <u>LORRAINE PARK Cem.</u>		24D. LOCATION (City, town, or county) (State) <u>WOODLAWN BALTO. MD.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>APR 11 1972</u>		25B. NAME OF REGISTRAR <u>[Signature]</u>		25C. FUNERAL DIRECTOR <u>Wm. Gook-Brooks Towson, Inc.</u> ADDRESS <u>Towson, MD.</u>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>72 03502</u>
BIRTH NO. <u>L-000</u>		72 03502		CERTIFICATE OF DEATH
1. NAME OF DECEASED (Type or Print) <u>JANET EILEEN LEE</u>		2. DATE AND HOUR OF DEATH <u>4.9.72</u> <u>3.08 P.</u> M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>University Hospital of Baltimore</u>		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>1607</u> C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>3243 Normount Avenue</u>		
5. SEX <u>Female</u>	6. RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-9-1954</u>	9. AGE (In years lost birthday) <u>18</u> If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>student</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>High School</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Raymond Lee</u>		
14. MOTHER'S MAIDEN NAME <u>Lois Terry</u>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		
16. SOCIAL SECURITY NO.		17. INFORMANT <u>Mrs. Lois Lee 3243 Normount Avenue</u>		
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Perforation of sigmoid colon</u> <u>Intestinal obstruction</u> <u>Dysgerminoma of the Ovary</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
MEDICAL CERTIFICATION OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>II</u>				
19A. DATE OF OPERATION <u>4.3.72</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>above</u>		20A. AUTOPSY? (Yes or No)
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from <u>4.1.72</u> to <u>4.9</u> 19 <u>72</u> that (I) (we) last saw the deceased alive on <u>4.9.72</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <u>J. Gerard Crowley</u>		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>4.9.72</u>
23C. PHYSICIAN'S NAME (Type) <u>J. GERARD CROWLEY</u>		23D. ADDRESS		
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>	24B. DATE <u>4-13-72</u>	24C. NAME OF CEMETERY OR CREMATORY <u>Mrs. Auburn Cem.</u>	24D. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>APR 11 1972</u>		25B. NAME OF REGISTRAR <u>John E. Jones, R.D.</u>		
25C. FUNERAL DIRECTOR <u>NUSTER FUNERAL HOME</u>		ADDRESS <u>3035 W. NORTH AVE.</u>		

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

L-000		72 03503		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 03503	
BIRTH NO.				1. NAME OF DECEASED (Type or Print) Lee, Walter R.			
2. DATE AND HOUR OF DEATH 4/6/72 10:40 P.M.				3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			
4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY Baltimore				5. SEX Male 6. RACE Negro			
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH 5/22/98			
9. AGE (In years last birthday) 73				10. A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Distributor			
11. BIRTHPLACE (State or foreign country) Virginia				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Walter Lee				14. MOTHER'S MAIDEN NAME Jannie Jackson			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) Unknown				16. SOCIAL SECURITY NO. 219-32-2698			
17. INFORMANT Ruth Lee				ADDRESS 1614 West Lafayette Avenue			
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTecedent CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Carcinoma of Prostate gland 9/69				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 10/13 1971 to 4/6 1972 that (I) (we) last saw the deceased alive on 4/6 1972 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Donald Stewart, M.D.				23B. DATE SIGNED 4/6/72			
23C. PHYSICIAN'S NAME (Type) Donald Stewart				23D. ADDRESS 2300 Garrison Blvd. (21216)			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4-11-72		24C. NAME OF CEMETERY OR CREMATORY Arbutus Memorial Park		24D. LOCATION Baltimore Co., Maryland	
25A. DATE REC'D BY HEALTH DEPT. APR 11 1972				25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS NUTTER FUNERAL HOME 3035 W. NORTH AVE	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

REG. NO. 72 03504

BIRTH NO. <u>R-152</u> 1. NAME OF DECEASED (Type or Print) <u>WILLIAM ROBINSON</u>		2. DATE AND HOUR OF DEATH <u>APRIL 8th 1972 4:45P</u> M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>SINAI HOSPITAL OF BALTIMORE</u> <u>42 INC</u>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>1511</u> C. CITY OR TOWN <u>BALTIMORE</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>4025 HILTON RD.</u>	
5. SEX <u>MALE</u>	6. RACE <u>NEGRO</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12/25/04</u>
9. AGE in years (last birthday) <u>67</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>	
11. BIRTHPLACE (State or foreign country) <u>Augusta, Ga.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William Robinson</u>		14. MOTHER'S MAIDEN NAME <u>? ?</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>212-03-0334</u>	
17. INFORMANT <u>AMrs. Bernice Gayle Jersey City, N. J.</u>		ADDRESS <u>330 Forrest St.</u>	
18. <u>162-117-019-0</u> CAUSE OF DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>CA OF LUNG E METASTASES</u> YEARS (B) DUE TO, OR AS A CONSEQUENCE OF: <u>ISCUD</u> YEARS (C) <u>INACTIVE PULMONARY TB</u> YEARS	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) <u>NO</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>4-8</u> 19 <u>72</u> to <u>4-8</u> 19 <u>72</u> that (I) (we) last saw the deceased alive on <u>4-8</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <u>F. Weinstein MD</u>		23B. DATE SIGNED <u>4-8-72</u>	
23C. PHYSICIAN'S NAME (Type) <u>FRANKLIN WEINSTEIN MD</u>		23D. ADDRESS <u>SINAI HOSPITAL -</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>4-12-72</u>	
24C. NAME of CEMETERY or CREMATORY <u>Mt. Auburn Cemetery</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore Maryland</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>APR 11 1972</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor Jr.</u>	
25C. FUNERAL DIRECTOR <u>NUTTER FUNERAL HOME</u>		ADDRESS <u>3035 W. NORTH AVE</u>	



72 03505

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 72 03505

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Frank Moses		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month 4 Day 6 Year 72 Hour M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 1409 Bloomingdale Rd.		3. DATE PRONOUNCED DEAD Month 4 Day 6 Year 72 Hour 8:30 p.m.	
6. SEX male		7. RACE Negro	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Balto.	
9. DATE OF BIRTH 10-17-1914		10. AGE (In years lost birthday) 57	
11. BIRTHPLACE (State or foreign country) South Carolina		12. CITIZEN OF WHAT COUNTRY? USA	
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) machine operator		15. MOTHER'S MAIDEN NAME Lucy Lowery	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		17. SOCIAL SECURITY NO. 247-20-2878	
18. INFORMANT Mrs. Mary Moses		ADDRESS 1409 Bloomingdale Road	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Cirrhosis of liver ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22D. TIME OF INJURY (APPROX.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Peter Lipkovic, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
DATE SIGNED 4/7/72			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4-11-72	
24C. NAME of CEMETERY or CREMATORY Mt. Auburn Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore Maryland	
25A. DATE REC'D BY HEALTH DEPT. APR 11 1972		25B. NAME OF REGISTRAR Robert E. Talley, M.D.	
25C. FUNERAL DIRECTOR NUTTER FUNERAL HOME		ADDRESS 3035 W. NORTH AV	

12-035

12-035

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

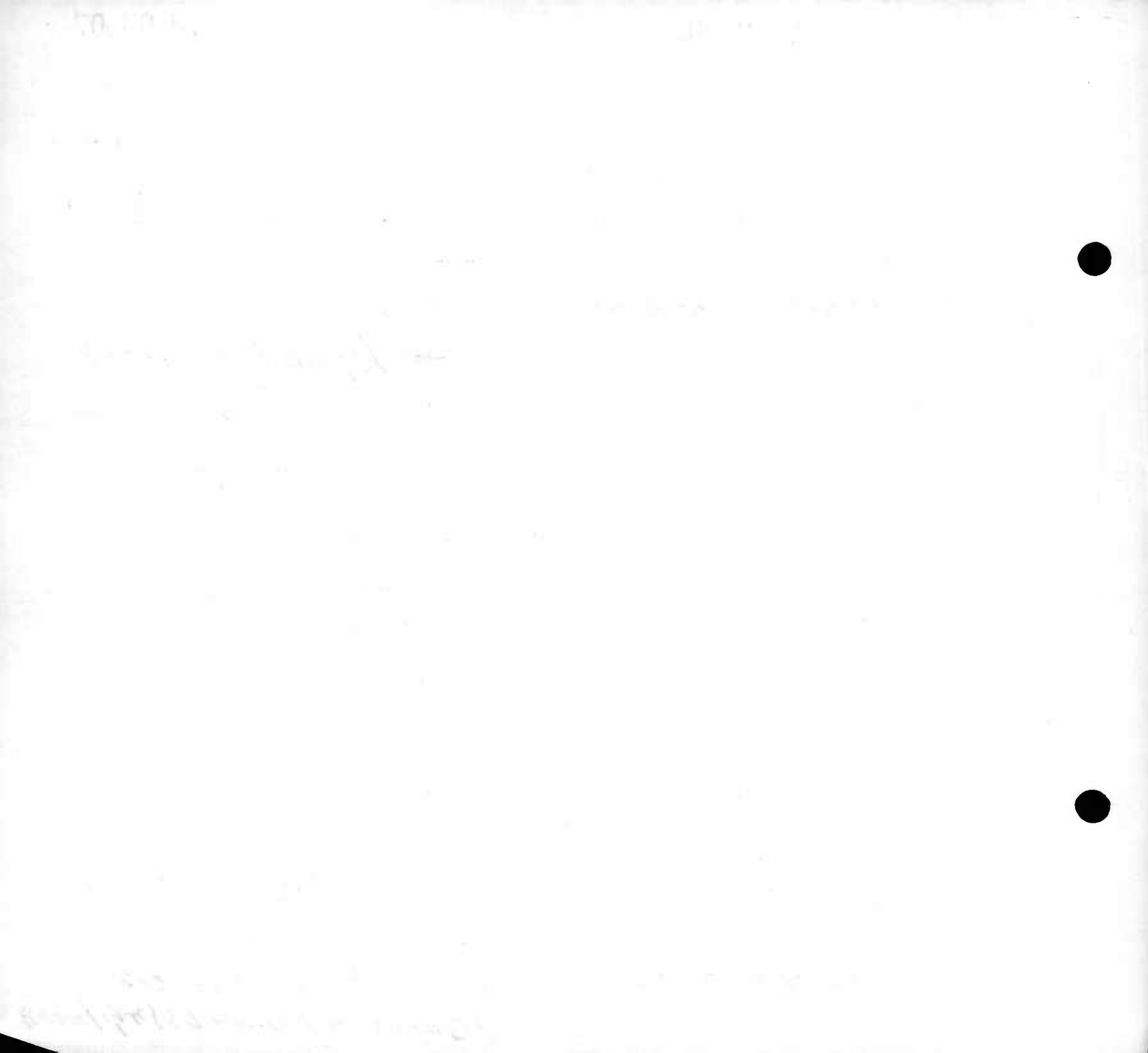
60-91-31 R-163 72 03506		72 03506		REG. NO. 72 03506	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) ROBERTS, James R.		2. DATE AND HOUR OF DEATH 4-9-72 8:20 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, If institution; residence before admission) A. STATE Maryland B. COUNTY 807		C. CITY OR TOWN Baltimore	
FULL NAME OF HOSPITAL OR INSTITUTION Baltimore City Hospital 4940 Eastern Avenue Baltimore, Maryland		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		E. STREET AND NUMBER 1706 East Oliver Street 21213	
5. SEX MALE	6. RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-16-18	9. AGE (in years last birthday) 53	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABOR		10B. KIND OF BUSINESS OR INDUSTRY Beth, Steel		11. BIRTHPLACE (State or foreign country) Virginia	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME James Roberts		14. MOTHER'S MAIDEN NAME Margaret Boothe	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 220-05-9523		17. INFORMANT 4940 Eastern Avenue Baltimore, Maryland 21224	
18. CAUSE OF DEATH 4-3-601 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: C.V.D. (B) Hypertension DUE TO, OR AS A CONSEQUENCE OF: (C)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 8-7 hrs.	
19A. DATE OF OPERATION 21		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (if in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 12:20 4-9 1972 to 7:30 4-9 1972 that (I) (we) last saw the deceased alive on 4-9 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE E. A. Timoll		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 4-9-72	
23C. PHYSICIAN'S NAME (Type) E. A. Timoll, M.D.		23D. ADDRESS Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland 21224			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4-13-72		24C. NAME of CEMETERY or CREMATORY Arbutus Mem. Park	
24D. LOCATION Arbutus, Md.		24E. NAME of REGISTRAR Milton F. Klicikson		24F. FUNERAL DIRECTOR 1129 N. Caroline St.	
25A. DATE REC'D BY HEALTH DEPT. APR 12 1972		25B. NAME OF REGISTRAR Milton F. Klicikson			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-652 72 03507		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 03507	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) Willie Barnes		2. DATE AND HOUR OF DEATH 4/11/72 1:40 a.m.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 31 Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland 21224		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 1502 C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 1823 N. Appleton Street 21227			
5. SEX Female	6. RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-27-23	9. AGE (In years last birthday) 48	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOME MAISON
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOME MAISON		10B. KIND OF BUSINESS OR INDUSTRY at Home		11. BIRTHPLACE (State or foreign country) Virginia	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME Nelson Wilson			
14. MOTHER'S MAIDEN NAME Lydia ABERNATHY		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO			
16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS BCH-Records 4940 Eastern Avenue Baltimore, Maryland 21224			
18. 4-26914-2509		CAUSE OF DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Bronchopneumonia			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) COMATOSE STATE DUE TO, OR AS A CONSEQUENCE OF:			
		(C) CVA - hascvd			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		Diabetes ? Cushing's			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 4/11/72 to 4/11/72 that (I) (we) last saw the deceased alive on 4/11/72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE [Signature] M.D.		23B. DATE SIGNED 4/11/72		23C. PHYSICIAN'S NAME (Type) [Signature]	
23D. ADDRESS 6004 East Pratt Street		24A. BURIAL CREMATION, REMOVAL (Specify) Removal			
24B. DATE 4-11-72		24C. NAME of CEMETERY or CREMATORY Family Plot		24D. LOCATION (City, town, or county) (State) KENNESAW VA	
25A. DATE REC'D BY HEALTH DEPT. APR 12 1972		25B. NAME OF REGISTRAR [Signature]		25C. FUNERAL DIRECTOR [Signature]	



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

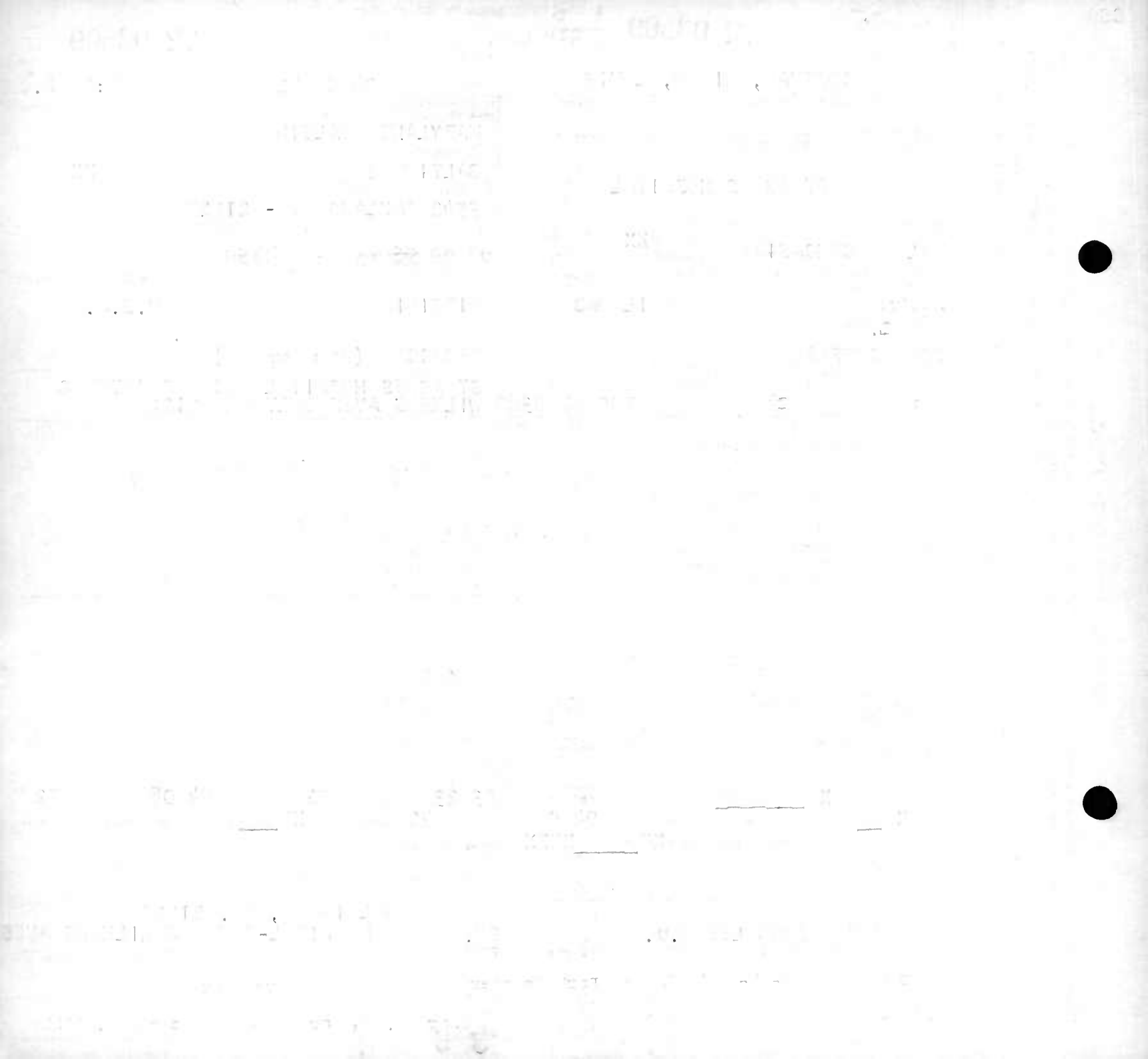
REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) JOHN MAYO RECTOR		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> April 6, 1972 11:40 A.M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 37 Mercy Hospital		3. DATE PRONOUNCED DEAD Month Day Year April 6, 1972 11:40 A.M.	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE D.C. B. COUNTY V 48	
6. SEX Male	7. RACE White	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	C. CITY OR TOWN Washington
9. DATE OF BIRTH Sept. 17, 1896		10. AGE (In years lost birthday) 75	D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
11. BIRTHPLACE (State or foreign country) Orange, Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	E. STREET AND NUMBER 2807 - 38th Street, N.W.
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret.-President		14B. KIND OF BUSINESS OR INDUSTRY E. Wash. Railway	13. FATHER'S NAME Lawrence Eppa Rector
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) Yes W.W.I		17. SOCIAL SECURITY NO.	15. MOTHER'S MAIDEN NAME Fannie Goodwin
18. INFORMANT Maryanna K. Rector, Wife, Same as #5		ADDRESS	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) DISEASE OR CONDITION E 814.7 ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
20A. DATE OF OPERATION 2			20B. CONDITION FOR WHICH OPERATION WAS PERFORMED
21. AUTOPSY? (Yes or No) Yes			
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) street	22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? Baltimore and Light Streets 401
22D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) 4-6-72 10:50 A.		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	22F. HOW DID INJURY OCCUR? Pedestrian struck by panel-truck
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Charles S. Springate, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) Charles S. Springate, M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED April 6, 1972 ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 4/10/72	24C. NAME of CEMETERY or CREMATORY Cedar Hill Cemetery	24D. LOCATION (City, town, or county) (State) Suitland, Pr. Geos. Co., Md.
25A. DATE REC'D BY HEALTH DEPT. APR 12 1972		25B. NAME OF REGISTRAR Robert E. [illegible]	25C. FUNERAL DIRECTOR JOSEPH GAWLER'S SON 5130 WISC. AVE., N. W. WASH., D. C. 20016

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

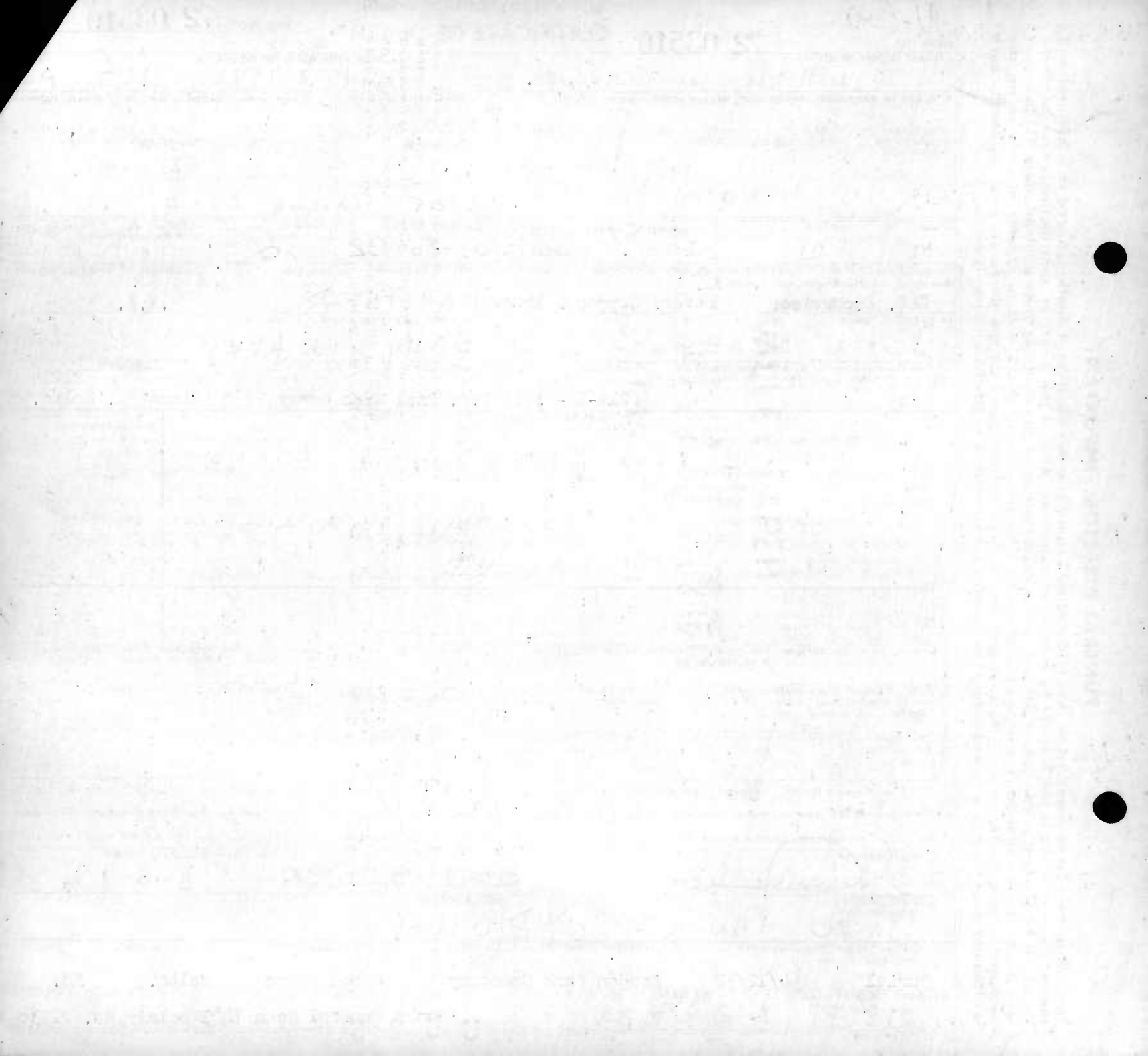
C-155 BIRTH NO.		72 03509		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 03509	
1. NAME OF DECEASED (Type or Print) COFFMAN, HIRAM, LOUIS				2. DATE AND HOUR OF DEATH 04 08 72 7:25 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 40 ST AGNES HOSPITAL				4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER 5542 OAKLAND RD - 21227			
5. SEX MALE	6. RACE CAUCASIAN	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 08 09 26 95	9. AGE (In years lost birthday) 76	10. Under 1 Yr. Months Days	11. Under 24 Hrs. Hours Min.	12. CITIZEN OF WHAT COUNTRY? U.S.A.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10B. KIND OF BUSINESS OR INDUSTRY RAILROAD		11. BIRTHPLACE (State or foreign country) VIRGINIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JOHN COFFMAN				14. MOTHER'S MAIDEN NAME REBECCA (Flecher)			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes W W I I		16. SOCIAL SECURITY NO. 705 07 6380		17. INFORMANT ST AGNES HOSPITAL RECORDS CATON & WILKENS AVES BALTO MD 21229			
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) IMMEDIATE CAUSE Thrombosis of Rt coronary artery DUE TO, OR AS A CONSEQUENCE OF: (B) Bronchopneumonia LUL DUE TO, OR AS A CONSEQUENCE OF: (C) Ca. of prostate gland			
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (X) (this hospital) attended the deceased from 03 23 1972 to 04 08 19 72 that (X) (we) last saw the deceased alive on 04 08 19 72 and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (X) (X) view the body after death.							
23A. SIGNATURE Joung Soon Lee M.D.				23B. DATE SIGNED 4/9/72		23C. PHYSICIAN'S NAME (Type) JOUNG SOON LEE M.D.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4-12-1972		24C. NAME of CEMETERY or CREMATORY Loudon Park Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. APR 12 1972		25B. NAME OF REGISTRAR Robert E. Hubbard, M.D.		25C. FUNERAL DIRECTOR Howard H. Hubbard, 4107 Wilkens Ave. 21229			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

N-600		72 03510		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 03510	
BIRTH NO.				72 03510			
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH			
William G. NEARY, Sr.				April 8 1972 12 ^L			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				A. STATE B. COUNTY			
44 UNION MEMORIAL HOSPITAL				MARYLAND. 2733			
				C. CITY OR TOWN		D. INSIDE CITY LIMITS?	
				BALTIMORE		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER			
				2705 LATONA ROAD			
5. SEX	6. RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months: Days		If Under 24 Hrs. Hours: Min.
M	W	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	03-20-92	80			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?
Ret. Supervisor			Revere Copper & Brass		MARYLAND		U.S.A.
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
JOHN NEARY				SALLY WARRY			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT	
No				215-10-0111A		ADDRESS 21214	
				Mrs. Opal Edna Neary 2709 Latona Rd. Balto.			
18. 412.4				CAUSE OF DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				(A) IMMEDIATE CAUSE			
(This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.)				PULMONARY EDEMA			
ANTECEDENT CAUSES				(B) PULMONARY Embolus			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.				DUE TO, OR AS A CONSEQUENCE OF:			
				(C) ASCVD			
II							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
O							
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
(Month) (Day) (Year) (Hour)		While At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>					
22. I certify that (I) (this hospital) attended the deceased from 04-07-72 19 to 19, that (I) (we) last saw the deceased alive on 04-08-72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE				23B. DATE SIGNED			
JAIRO LANIER				A-8-72			
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
DAIRO LANIER				MD UMH			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial		4/12/72		Loudon Park Cemetery		Baltimore Balto. Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
APR 12 1972		Robert J. [unclear]		Lassahn Funeral Home		7401 Belair Rd. 21236	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 03511	
BIRTH NO. 1. NAME OF DECEASED (Type or Print) Albert Seiler		2. DATE AND HOUR OF DEATH April 10, 1972.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 90 Harford Gardens Nursing Home		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 1512 Burnwood Road			
5. SEX Male	6. RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 30, 1879.	9. AGE (In years last birthday) 92	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10B. KIND OF BUSINESS OR INDUSTRY Self-Employed		11. BIRTHPLACE (State or foreign country) Germany 12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Christian Seiler			14. MOTHER'S MAIDEN NAME Luitgarde Hauser		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 220-44-8599		17. INFORMANT Mr. Albert Klotz ADDRESS (Same)	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH v days v yrs	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from March 19 72 to April 10 19 72, that (I) last saw the deceased alive on April 10 19 72 and that in (my) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did not) view the body after death.					
23A. SIGNATURE Allan A. Spier				23B. DATE SIGNED 4/11/72	
23C. PHYSICIAN'S NAME (Type) Allan A Spier				23D. ADDRESS 1501 Pentridge Rd.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4/13/72.		24C. NAME OF CEMETERY or CREMATORY Holy Redeemer Cemetery	
24D. LOCATION (City, town, or county) (State) Baltimore, Md.		25A. DATE REC'D BY HEALTH DEPT. APR 12 1972			
25B. NAME OF REGISTRAR Robert E. ...		25C. FUNERAL DIRECTOR Leonard J Ruck Inc. Balto. Md. 21214			

• • • • •

44

Figure 1. Schematic representation of the experimental design. The subjects were divided into two groups: control and experimental. The control group received a standard diet, while the experimental group received a diet supplemented with 0.5% of the active ingredient. The subjects were then subjected to a 12-week period of physical training. The results were then compared between the two groups.

S-530

72 03512

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 72 03512

BIRTH NO.

1. NAME OF DECEASED (Type or Print) KENNETH SMITH		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year April 5, 1972 Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 401 Yale Avenue		3. DATE PRONOUNCED DEAD Month Day Year April 5, 1972 Hour 5:50 P.M.	
6. SEX Male		7. RACE White	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		C. CITY OR TOWN Baltimore	
9. DATE OF BIRTH 12-1-07		10. AGE (In years lost birthday) 64	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13. FATHER'S NAME GEORGE SMITH		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SHIPYARD	
15. MOTHER'S MAIDEN NAME ALMA M GROVES		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) NO	
17. SOCIAL SECURITY NO. 173-053084		18. INFORMANT W. R. ELLIS	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Hypertensive and arteriosclerotic cardiovascular disease (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____ ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) No			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		22D. TIME OF INJURY (Month) (Day) (Year) (Hour)	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Charles S. Springate, M.D. EXAMINER'S NAME (Type) Charles S. Springate, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED April 6, 1972			
24A. BURIAL CREMATION, REMOVAL (Specify) CREMATION		24B. DATE 4/8/72	
24C. NAME OF CEMETERY or CREMATORY CEDAR HILL CREMATORY		24D. LOCATION (City, town, or county) (State) SUITLAND MD	
25A. DATE REC'D BY HEALTH DEPT. APR 12 1972		25B. NAME OF REGISTRAR W. W. CHAMBERS	
25C. FUNERAL DIRECTOR		25D. ADDRESS 6 RIVERDALE	

72-03512-0003507

ST-20

ST-20

ST-20

ST-20

ST-20

ST-20

ST-20

ST-20

ST-20

ST-20

ST-20

ST-20

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

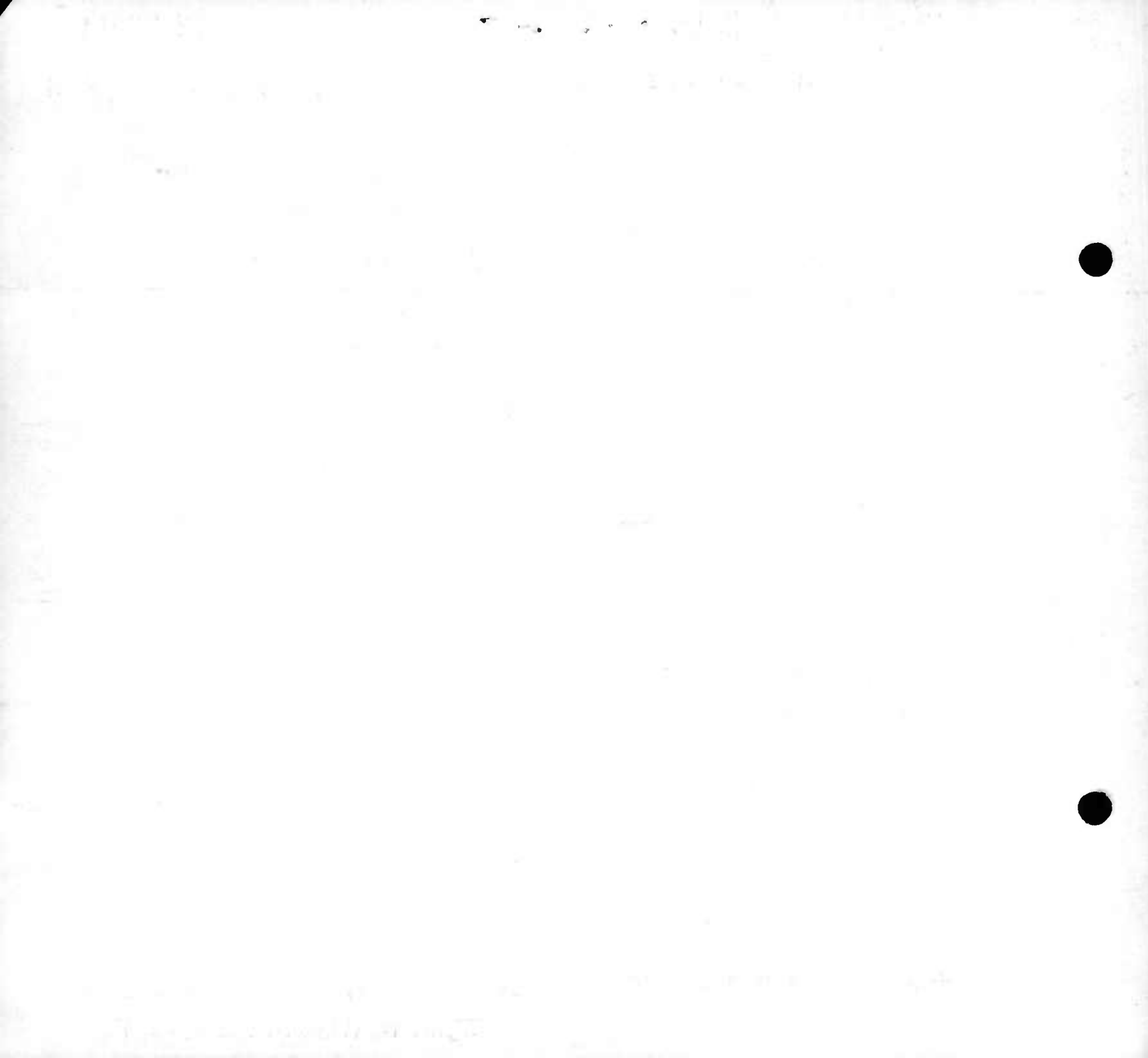
BIRTH NO. B-562		BALTIMORE CITY HEALTH DEPARTMENT		72 03513		72 03513	
1. NAME OF DECEASED (Type or Print) NUNZIO BONARRIGO				2. DATE AND HOUR OF DEATH April 9, 1972 2 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MD B. COUNTY BALTO			
FULL NAME OF HOSPITAL OR INSTITUTION 00 1715 EAST 33RD ST		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN PARKVILLE		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX M		6. RACE F W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Dec 15 1874 47	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Barber		10B. KIND OF BUSINESS OR INDUSTRY SELF		11. BIRTHPLACE (State or foreign country) Italy		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Joseph BONARRIGO				14. MOTHER'S MAIDEN NAME UNKNOWN			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO.		17. INFORMANT Joseph BONARRIGO		ADDRESS 2925 MANN AVE	
18. 4-269-1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphemia, etc. It means the disease, injury or complication which caused death.) Cerebral accident ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Generalized arteriosclerosis				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Cerebral accident (B) Generalized arteriosclerosis (C) _____			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 day			
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from Jan 1971 to 4/9 1972 that (I) (we) lost saw the deceased alive on 4/8 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
23A. SIGNATURE Conrad L. Richter				23B. DATE, SIGNED 4/11/72		23C. PHYSICIAN'S NAME (Type) CONRAD L. Richter MD	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 4/12/72		24C. NAME OF CEMETERY or CREMATORY New Cathedral		24D. LOCATION (City, town, or county) (State) Baltimore MD	
25A. DATE REC'D BY HEALTH DEPT. APR 12 1972		25B. NAME OF REGISTRAR MD		25C. FUNERAL DIRECTOR Charles F. Evans			
				ADDRESS 8802 Hartford Rd			



Pl. hold Body for autopsy
BODY RECEIVED BY MEDICAL EXAMINER
FUNERAL DIRECTOR: IMPORTANT
Cautious 7:35 AM

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-400		72 03514		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 03514	
BIRTH NO.				1. NAME OF DECEASED (Type or Print) HAROLD S. BOYLE			
2. DATE AND HOUR OF DEATH 4-9-72 10:30 A.M.				3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) CHURCH HOME HOSPITAL			
4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE M.D. B. COUNTY		C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		E. STREET AND NUMBER 2202 E. PRATT ST.	
5. SEX M		6. RACE A W.		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7-28-94	
9. AGE (In years last birthday) 77		10. UNDER 1 Yr. Months Days		11. UNDER 24 Hrs. Hours Min.		12. CITIZEN OF WHAT COUNTRY AMER.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retd.				10B. KIND OF BUSINESS OR INDUSTRY Retd.			
13. FATHER'S NAME HUGH BOYLE				14. MOTHER'S MAIDEN NAME BERTHA BENNINGTON			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO				16. SOCIAL SECURITY NO. 217 16 2471		17. INFORMANT ADDRESS CHURCH HOME HOSPITAL	
18. CAUSE OF DEATH NOT A MEDICAL EXAMINER'S DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) CHIEF OR ASST. MEDICAL EXAMINER ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). 19A. DATE OF OPERATION 3-30-72 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED CHR. ARTERIAL INSUFFICIENCY, GANGLION CT. FOOT. 20A. AUTOPSY? (Yes or No) YES 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Indify medical examiner) NO 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) HOSPITAL 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) PATIENTS ROOM 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) APRIL 9 72 2 AM 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/> 21F. HOW DID INJURY OCCUR? NOT KNOWN				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH (A) IMMEDIATE CAUSE POSS. MYOCARDIAL DUE TO, OR AS A CONSEQUENCE OF: INFARCTION OR POSS. MASSIVE PULMONARY EMBOLISM (B) DUE TO, OR AS A CONSEQUENCE OF: ARTERIAL SCLEROSIS (DIABETES MELLITUS) (C) POSSIBLE RACE. D.D. DIABETES MELLITUS, ASCVD 3 HOURS MANY YEARS 3 HOURS MANY YEARS			
22. I certify that (I) (this hospital) attended the deceased from 3-22-72 19 to 4-9-1972 that (H) (we) last saw the deceased alive on 4-9-1972 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				23A. SIGNATURE A. Mehl M.D. 23B. DATE SIGNED 4/9/72			
23C. PHYSICIAN'S NAME (Type) Dr. ASHWIN MEHTA M.D.				23D. ADDRESS CHURCH HOME HOSP. BALTO MD. 21231			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 4-11-72		24C. NAME OF CEMETERY OR CREMATORY TABERNACLE		24D. LOCATION (City, town, or county) (State) WHITEFORD, HARFORD, MD.	
25A. DATE REC'D BY HEALTH DEPT. APR 12 1972		25B. NAME OF REGISTRAR Robert F. [unclear]		25C. FUNERAL DIRECTOR JOHN H. HARKINS, DELTA, PA.		25D. ADDRESS	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 03515	
BIRTH NO. 72 03515		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) HICKS CHARLES E			2. DATE AND HOUR OF DEATH 4-7-72 7:25 P.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Provident Hospital 39 2600 Liberty Heights			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY 2802 C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 2800 Silver Hill Avenue 21207		
5. SEX Male	6. RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-11-95	9. AGE (In years last birthday) 76	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired XXXXXXXXXX			10B. KIND OF BUSINESS OR INDUSTRY Claim Agent B&O		11. BIRTHPLACE (State or foreign country) Virginia
12. CITIZEN OF WHAT COUNTRY? USA			13. FATHER'S NAME Thomas Hicks		
14. MOTHER'S MAIDEN NAME Hopkins			15. Was Deceased Ever In U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes Navy		
16. SOCIAL SECURITY NO. 911-18-8232			17. INFORMANT Marie Hicks-2800 Silver Hill Avenue #7		
18. 4-36-91 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CUA (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: CUA (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION 4-3-72		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that W (this hospital) attended the deceased from 3-25-1972 to 4-7-1972 that N (we) last saw the deceased alive on 4-7-1972 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Rayman I. Alley MD DEGREE				23B. DATE SIGNED 4-7-72	
23C. PHYSICIAN'S NAME (Type) RAYMAN I. ALLEY MD DEGREE				23D. ADDRESS PROVIDENT HOSP INC.	
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial		24B. DATE 4-11-72		24C. NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery	
24D. LOCATION (City, town, or county) (State) Baltimore, Maryland		25A. DATE REC'D BY HEALTH DEPT. APR 12 1972			
25B. NAME OF REGISTRAR Robert S. Taylor, M.D.		25C. FUNERAL DIRECTOR Armstrong Funeral Chapel-4600 Liberty Hts			

1000

1000 1000 1000 1000

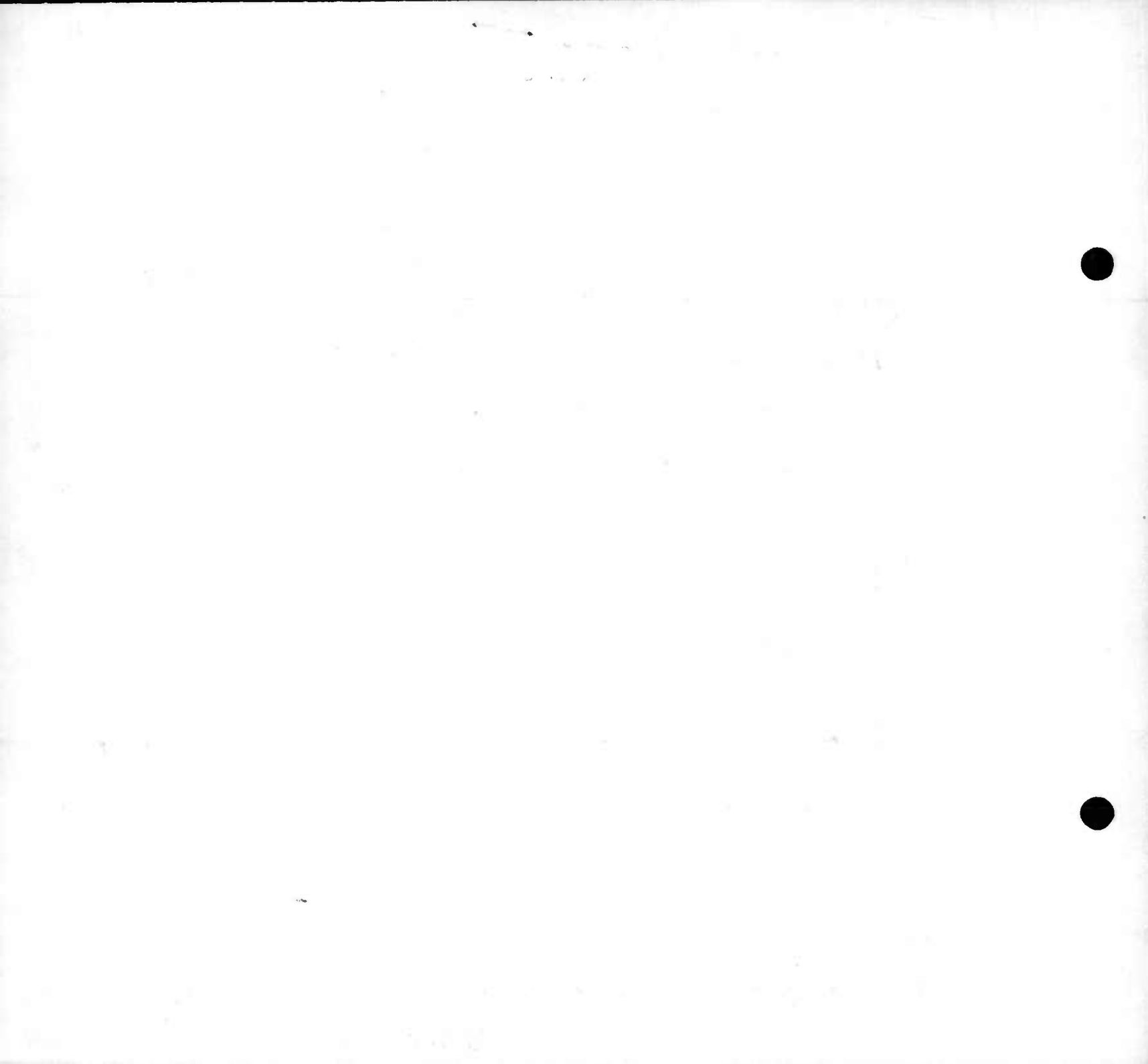
1000 1000 1000 1000

1000 1000 1000 1000

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

T-560		72 03516		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 03516	
BIRTH NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <u>JEFFREY A. TOWER</u>				2. DATE AND HOUR OF DEATH <u>4/7/72</u> <u>11:30</u> P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>UNIV. OF MARYLAND HOSPITAL</u> <u>38</u>				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MD.</u> B. COUNTY <u>WASHINGTON</u> C. CITY OR TOWN <u>FORT RITCHIE</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>BLD 465 Apt 8</u>			
5. SEX <u>M</u>	6. RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-25-70</u>	9. AGE (in years last birthday) <u>1</u>	If Under 1 Yr. Months Days	If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Chief</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>PENN.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Donald F. Tower</u>				14. MOTHER'S MAIDEN NAME <u>Jean M. ROBERT</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>—</u>		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>Donald Tower</u>		ADDRESS <u>Same</u>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Salicylate Intox.</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>II</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <u>—</u>				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>SALICYLATE INTOX.</u> (B) DUE TO, OR AS A CONSEQUENCE OF: <u>—</u> (C) <u>—</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>4 Days</u>	
19A. DATE OF OPERATION <u>4/5/72</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>—</u>		20A. AUTOPSY? (Yes or No) <u>YES</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>—</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indify medical examiner) <input checked="" type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>Home</u>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <u>77 Ritchie, Md 71-00</u>			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) <u>4 5 72 ?</u>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? <u>Deceased ingested aspirin</u>			
22. I certify that (I) (this hospital) attended the deceased from <u>APRIL 5</u> 19 <u>72</u> to <u>APRIL 8</u> 19 <u>72</u> that (I) (we) last saw the deceased alive on <u>APRIL 8</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>Edward H. Gabel</u>				23B. DATE SIGNED <u>April 8, 1972</u>		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>	
23C. PHYSICIAN'S NAME (Type) <u>EDWARD H. GABEL D1</u>				23D. ADDRESS <u>1723 STELLA CT BALT. MD</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>4/10/72</u>		24C. NAME OF CEMETERY or CREMATORY <u>Chapman Christi. Cem.</u>		24D. LOCATION (City, town, or county) (State) <u>Chambersburg - Franklin Co. Pa.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>APR 12 1972</u>		25B. NAME OF REGISTRAR <u>—</u>		25C. FUNERAL DIRECTOR ADDRESS <u>Elite Funeral Home Reisterstown Md</u>			



1. NAME OF DECEASED (Type or Print) DOROTHY FREDERICKS					2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.				
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 38 University Hospital					3. DATE PRONOUNCED DEAD Month Day Year Hour 4 10 1972 12:30p.m.				
6. SEX female					7. RACE white				
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>					C. CITY OR TOWN Dover				
9. DATE OF BIRTH 1/29/1908					10. AGE (In years last birthday) 64				
11. BIRTHPLACE (State or foreign country) New Jersey					12. CITIZEN OF WHAT COUNTRY? U.S.A.				
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife					14B. KIND OF BUSINESS OR INDUSTRY at home				
15. MOTHER'S MAIDEN NAME Unknown					16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No				
17. SOCIAL SECURITY NO. -					18. INFORMANT George Fredericks				
19. CAUSE OF DEATH Arteriosclerotic cardiovascular disease					ADDRESS Sunny Hill Rd. N.J.				
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.					(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:				
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					(B) DUE TO, OR AS A CONSEQUENCE OF:				
20A. DATE OF OPERATION					20B. CONDITION FOR WHICH OPERATION WAS PERFORMED				
21. AUTOPSY? (Yes or No) no									
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.					22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				
22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)									
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)					22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				
22F. HOW DID INJURY OCCUR?									
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Russell S. Fisher, M.D.					CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 4-10-72				
24A. BURIAL CREMATION, REMOVAL (Specify) Burial					24B. DATE 4/13/72				
24C. NAME OF CEMETERY or CREMATORY Pleasant Hill Cemetery					24D. LOCATION (City, town, or county) (State) Randolph Township, N.J.				
25A. DATE REC'D BY HEALTH DEPT. APR 18 1972					25B. NAME OF REGISTRAR Robert E. Fisher, M.D.				
25C. FUNERAL DIRECTOR John J. Cowan & Son Inc.					ADDRESS Hollinsworth				



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

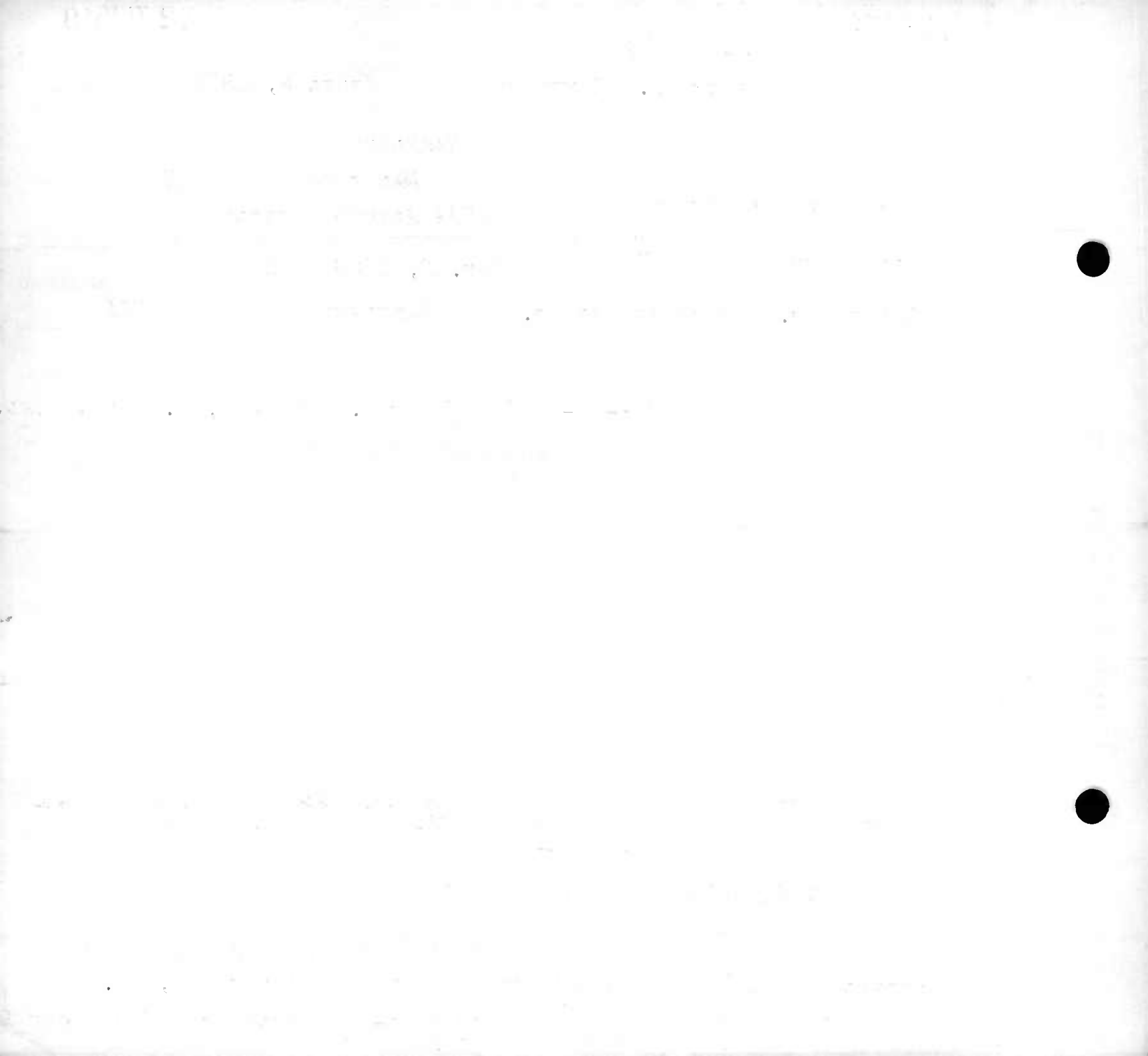
B-430		72 03518		BALTIMORE CITY HEALTH DEPARTMENT		72 03518	
BIRTH NO.				REG. NO.			
1. NAME OF DECEASED (Type or Print) <u>Blattau, Mrs. IDA L.</u>				2. DATE AND HOUR OF DEATH <u>4-8-72</u> <u>11:55 P.M.</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <u>34</u> <u>Bon Secours Hospital</u>				A. STATE <u>MD.</u> B. COUNTY <u>BALTO</u>			
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX <u>Female</u>				6. RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE KEEPER</u>				10B. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>		8. DATE OF BIRTH <u>5-16-82</u>	
13. FATHER'S NAME <u>GUSTAV FREDERICK</u>				14. MOTHER'S MAIDEN NAME <u>NOT KNOWN</u>		9. AGE (in years last birthday) <u>89</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or doles of service) <u>—</u>				16. SOCIAL SECURITY NO. <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>MD.</u>	
17. INFORMANT <u>Mrs. Louis DeChriste - 408 Greenlow Rd</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshtenio, etc. It means the disease, injury or complication which caused death.) DISEASE OR CONDITION, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Acute M.I.</u>				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 wk.</u>			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <u>II</u>							
19A. DATE OF OPERATION <u>4/8/72</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>4/7/72</u> 19 to <u>4/8/72</u> 19 that (I) (we) last saw the deceased alive on <u>4/8/72</u> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>Yungong Yungongyung</u>				23B. DATE SIGNED <u>4/8/72</u>		23C. PHYSICIAN'S NAME (Type) <u>YUNYONG YUNYONGYUNG</u>	
23D. ADDRESS <u>BON SECOURS HOSPITAL</u>				23E. DEGREE <u>DEGREE</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>4-12-72</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Holy Redeemer Cem</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore Md.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>APR 12 1972</u>		25B. NAME OF REGISTRAR <u>...</u>		25C. FUNERAL DIRECTOR <u>...</u>		25D. ADDRESS <u>...</u>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

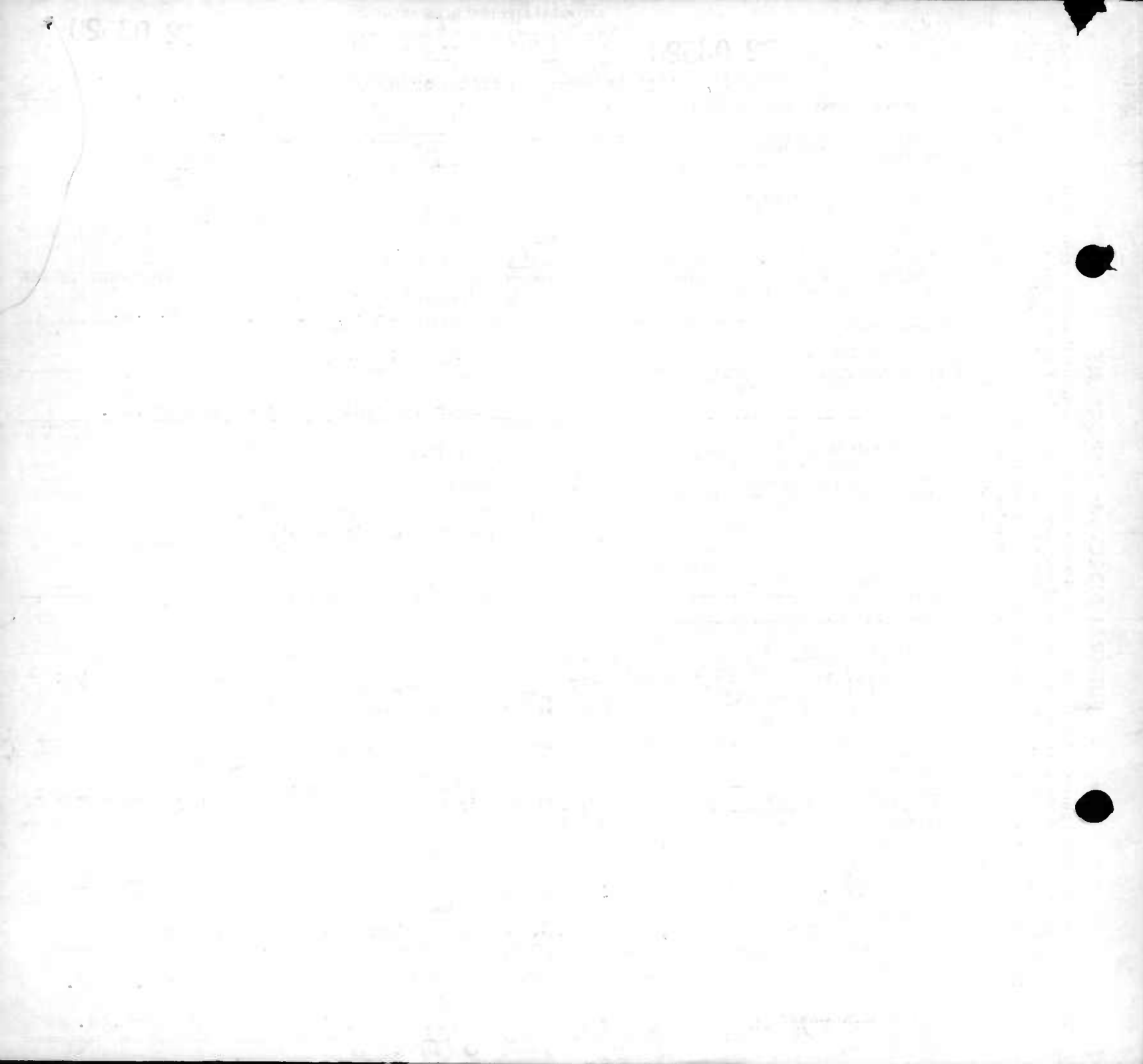
BALTIMORE CITY HEALTH DEPARTMENT		72 03519		REG. NO. 72 03519	
BIRTH NO. 72 03519		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) FRANK H. LAWRENCE		2. DATE AND HOUR OF DEATH APRIL 9, 1972 10.30 A. M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 3711 ALAMEDA CIRCLE		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY 902 C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 3711 ALAMEDA CIRCLE			
5. SEX MALE	6. RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 2, 1890	9. AGE (In years last birthday) 71	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SALES REP. ROBINSON OIL Co.		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME ?		14. MOTHER'S MAIDEN NAME ?			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 214-03-38914		17. INFORMANT FRANK H. LAWRENCE, JR. ADDRESS DELMAR DEL	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic Heart Disease		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 24RS.	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
		(B) DUE TO, OR AS A CONSEQUENCE OF:			
		(C) DUE TO, OR AS A CONSEQUENCE OF:			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Aug 15 1968 to April 9 1972 that (I) (we) last saw the deceased alive on April 6 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Albert J. HimeifARB				23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) Albert J. HimeifARB				23D. ADDRESS 222 W. Cold Spring Lane	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 4/11/72		24C. NAME of CEMETERY or CREMATORY PARKWOOD CEMETERY	
				24D. LOCATION (City, town, or county) (State) BALTIMORE, MD.	
25A. DATE REC'D BY HEALTH DEPT. APR 12 1972		25B. NAME OF REGISTRAR ROBERT E. JONES		25C. FUNERAL DIRECTOR MICHAEL WAEDEFELD ADDRESS HOME 6500 YORK R	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

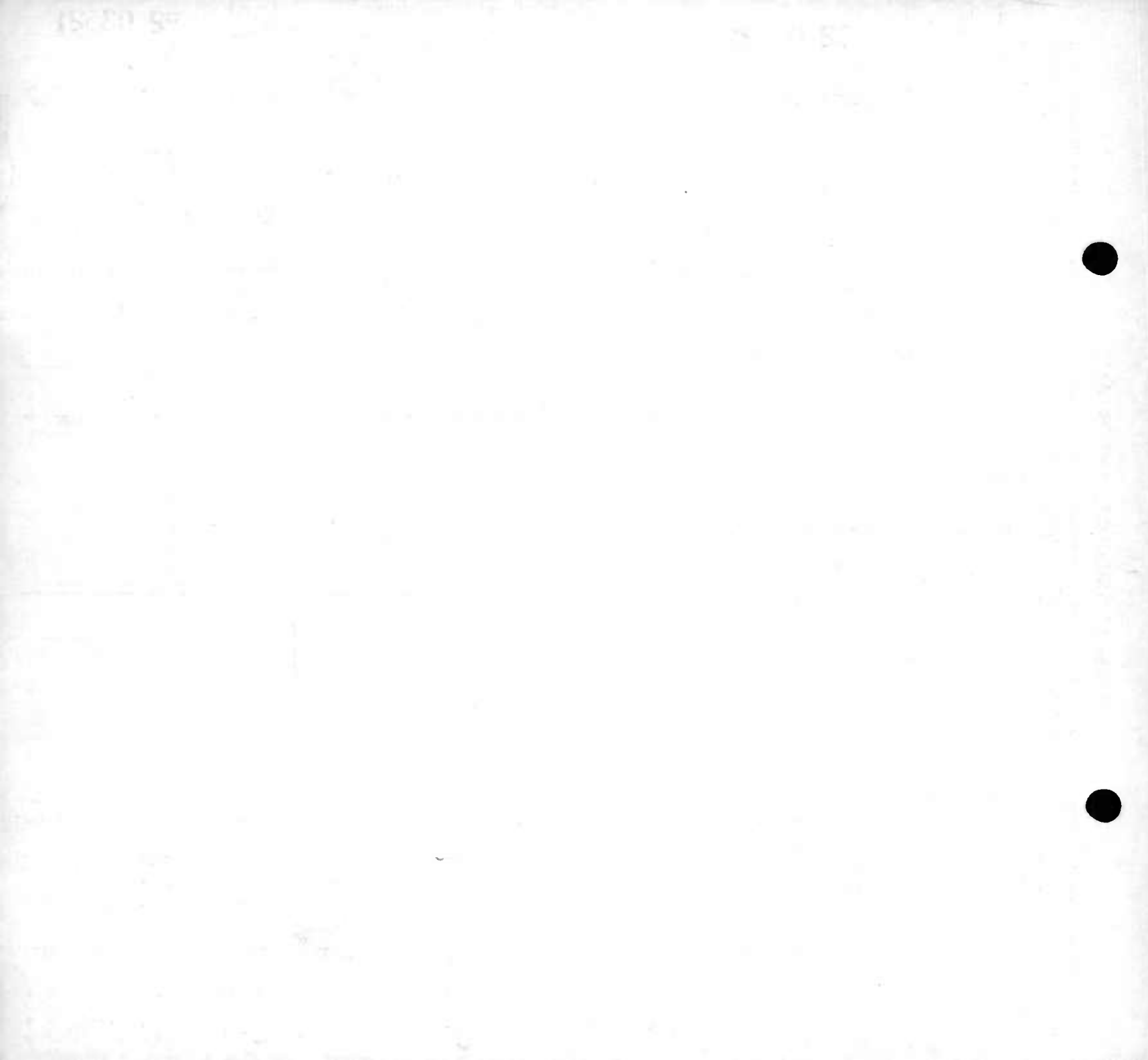
BALTIMORE CITY HEALTH DEPARTMENT				X		REG. NO. 72 03520	
C-165 BIRTH NO. 72 03520				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) COBURN, Baby Boy xxx Vincent Jordan				2. DATE AND HOUR OF DEATH 4/5/72 8:30 AM - 4/5/72 M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE B. COUNTY			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) The Johns Hopkins Hospital				Maryland Frederick C. CITY OR TOWN Brunswick D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 101 Garden Apartments			
5. SEX Male	6. RACE Cauc.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/3/72	9. AGE (In years lost birthday) 2 days	If Under 1 Yr. Months: Days: Hours: Min. 2		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) General Hospital Charleston W. VA.		12. CITIZEN OF WHAT COUNTRY? u.s.a.
13. FATHER'S NAME Elmer Coburn				14. MOTHER'S MAIDEN NAME Sylvia Grogg			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS Elmer Vincent Coburn-Brunswick, Md.		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH ? SEPSIS, gastroenteritis (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: PROM, prolonged labor, unstable delivery (B) DUE TO, OR AS A CONSEQUENCE OF: (C)			
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
19A. DATE OF OPERATION 3 4/3/72		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED gastroenteritis		20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (1) (this hospital) attended the deceased from 4/3 19 72 to 4/5 19 72 that (1) (we) lost saw the deceased alive on 4/5 19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.							
23A. SIGNATURE S. Broske mo				23B. DATE SIGNED 4/5/72		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>	
23C. PHYSICIAN'S NAME (Type) Stuart Broske, M.D.				23D. ADDRESS The Johns Hopkins Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify) burial		24B. DATE 4/7/72		24C. NAME OF CEMETERY or CREMATORY Rest Haven Memorial Gardens		24D. LOCATION (City, town, or county) (State) Hansonville Fred. Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR Feete Funeral Home		ADDRESS Brunswick, Md.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 03521	
H-62072 03521		CERTIFICATE OF DEATH			
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		HARRIS, CONNOR G		4/11/72 12:55 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE & COUNTY		
FULL NAME OF HOSPITAL OR INSTITUTION BON SECOURS HOSPITAL			C. CITY OR TOWN BALTIMORE		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
			E. STREET AND NUMBER 3312 Auchen-Trolley Terrace		
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. If Under 1 Yr. Months Days
Female	Negro		2-29-90	82	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Retired				MARYLAND	
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
William Holland			Sarah Crampton		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
		214-4047992		CHART B.S.H.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Cordine standstill B) Acute myocardial infarction C) DUE TO, OR AS A CONSEQUENCE OF:		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 3-17-72 to 4-10-1972 1972 that (I) (we) last saw the deceased alive on 4-10-1972 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Vikram Thitivarana			23B. DATE SIGNED 4-10-72		
23C. PHYSICIAN'S NAME (Type) VIKRAM THITIVARANA			23D. ADDRESS BON SECOURS HOSPITAL		
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		4-16-72		Arbutus Mem. Cemetery Balto Md.	
25A. DATE REC'D BY HEALTH DEPT. APR 12 1972		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR Charles Evans Hughes	
				ADDRESS 21223 1532 Hollings	



FUNERAL DIRECTOR: IMPORTANT

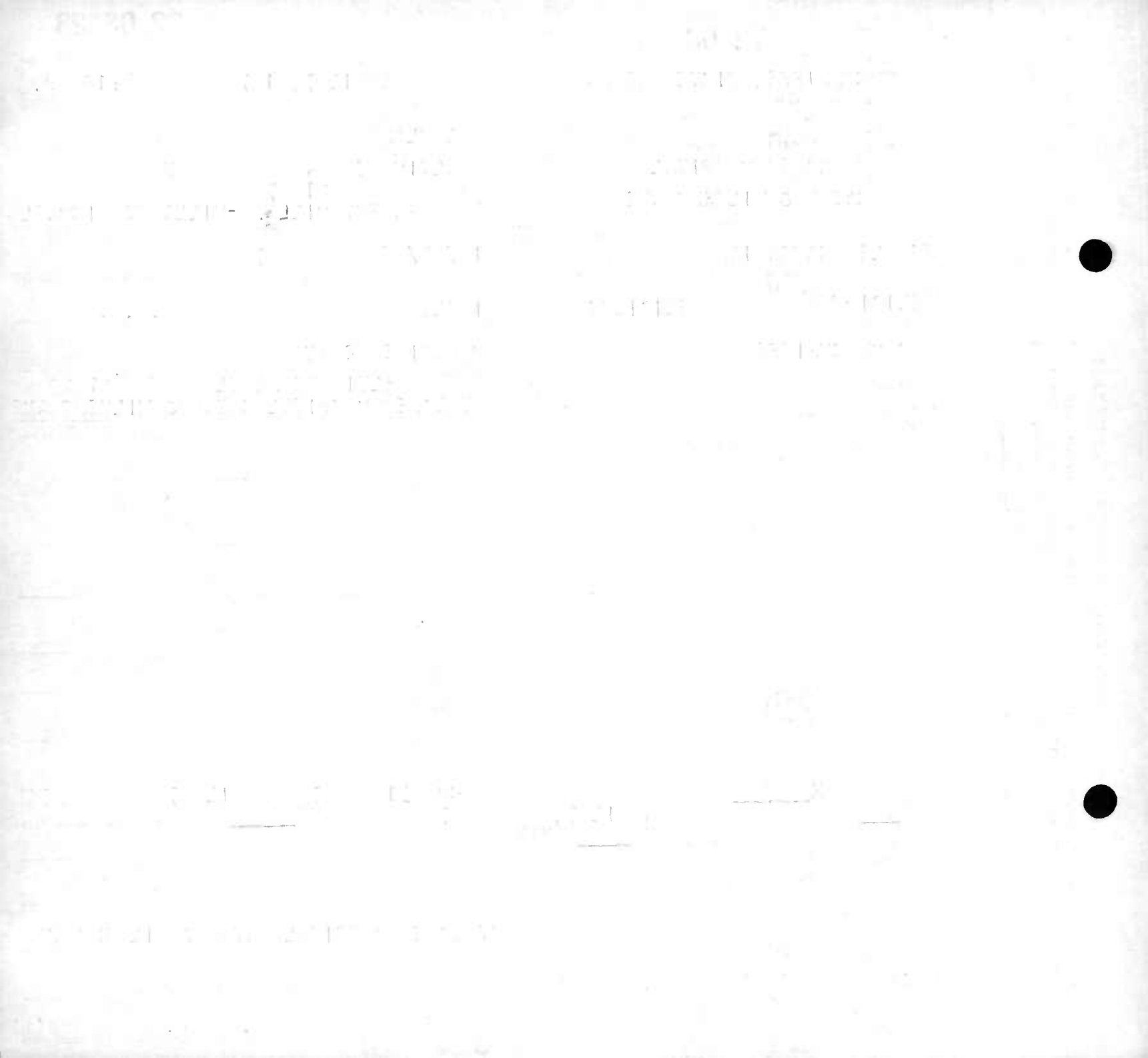
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>72 03522</u>	
BIRTH NO. <u>72 03522</u>		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <u>RALPH Thomas</u>			2. DATE AND HOUR OF DEATH <u>4-8-72</u> <u>3:40 A</u> M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>MARYLAND GEN. Hosp.</u>			4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <u>MD</u> B. COUNTY <u>1102</u>		
			C. CITY OR TOWN <u>BALTIMORE</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER <u>7 - W - Preston #02</u>		
5. SEX <u>M</u>	6. RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-22-14</u>	9. AGE (In years last birthday) <u>58</u>	10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>VETERAN</u>		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>PA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS		
18. <u>30-21</u> CAUSE OF DEATH			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) IMMEDIATE CAUSE <u>chronic alcoholism</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>Dehydration - Electrolyte Imbalance</u> DUE TO, OR AS A CONSEQUENCE OF: (C) _____		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, locality, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>4-8-72</u> 19 <u>72</u> to <u>4-8-72</u> 19 <u>72</u> that (I) (we) last saw the deceased alive on <u>4-8-72</u> 19 <u>72</u> and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>[Signature]</u> DEGREE				23B. DATE SIGNED <u>4-8-72</u>	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
<u>DR MELENCIO VENTURA</u>		<u>2404 EAST RIDGE Rd Timonium</u>			
24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY		24D. LOCATION (City, town, or county) (State)	
<u>Burial</u>	<u>4-14-72</u>	<u>Gelleburry Nat Cemetery</u>		<u>Gettysburg Pa.</u>	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
<u>APR 12 1972</u>		<u>[Signature]</u>		<u>Charles E. Hughes 1532 Hollins St</u>	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				72 03523		72 03523	
BIRTH NO. 0-510				72 03523		72 03523	
1. NAME OF DECEASED (Type or Print) CUNIFFE, SISTER BERNARD				2. DATE AND HOUR OF DEATH APRIL 7, 1972		4:15 P. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE B. COUNTY		C. CITY OR TOWN	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 40 ST AGNES HOSPITAL CATON & WILKENS AVE				MARYLAND		BALTIMORE	
D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				E. STREET AND NUMBER 4000 FOREST HILL RD-VILLA ST MICHAEL		21207	
5. SEX FEMALE		6. RACE CAUCASIAN		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12/04/96	
9. AGE (in years last birthday) 75		10. UNDER 1 Yr. Months Days If Under 24 Hrs. Min.		11. BIRTHPLACE (State or foreign country) IRELAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RELIGIOUS				10B. KIND OF BUSINESS OR INDUSTRY RELIGIOUS			
13. FATHER'S NAME JOHN CUNIFFE				14. MOTHER'S MAIDEN NAME HONORINE KENNY			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO				16. SOCIAL SECURITY NO. J1 219-54-0593		17. INFORMANT BALTIMORE MARYLAND ADDRESS 21229 ST AGNES HOSPITAL CATON & WILKENS AVE	
18. CAUSE OF DEATH				DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Massive cerebral embolism		16 hrs	
				(B) DUE TO, OR AS A CONSEQUENCE OF: Arteriosclerotic Cardio Vasc. Dis		25 yrs.	
				(C) _____		_____	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				Right bundle branch block		16 hrs.	
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?		22. I certify that (1) (this hospital) attended the deceased from MARCH 31 1972 to APRIL 7 1972 that (1) (we) last saw the deceased alive on APRIL 7 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.		23A. SIGNATURE Daniel Huerta M.D.	
23B. DATE SIGNED April 7/72		23C. PHYSICIAN'S NAME (Type) Daniel Huerta M.D.		23D. ADDRESS ST AGNES HOSPITAL CATON & WILKENS AVE		23E. FUNERAL DIRECTOR STEWART & MOWEN CO. 108 W. North Ave (1)	
24A. BURIAL CREMATION REMOVAL (Specify) Burial		24B. DATE 4/10/72		24C. NAME of CEMETERY or CREMATORY St. Joseph's Cemetery		24D. LOCATION (City, town, or county) (State) Emmitsburg, Maryland	
25A. DATE REC'D BY HEALTH DEPT. APR 12 1972		25B. NAME of REGISTRAR [Signature]		25C. FUNERAL DIRECTOR STEWART & MOWEN CO. 108 W. North Ave (1)		25D. ADDRESS	



P-636

72 03524

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

72 03524

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Hill Darryl Porter		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month 4 Day 7 Year 72 Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 42 Sinai Hospital		3. DATE PRONOUNCED DEAD Month 4 Day 7 Year 72 Hour 7:30 p.m.	
5. USUAL RESIDENCE (Where deceased lived. If Institution: residence before admission) A. STATE Md. B. COUNTY 1504		6. SEX male 7. RACE Negro B. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> C. CITY OR TOWN Balto. D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
9. DATE OF BIRTH 10. AGE (In years lost birthday) 17 If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.		E. STREET AND NUMBER 2217 Clifton	
11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student		13. FATHER'S NAME Calvert M. Porter	
14B. KIND OF BUSINESS OR INDUSTRY		15. MOTHER'S MAIDEN NAME Ella Mae Hill	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		17. SOCIAL SECURITY NO.	
18. INFORMANT Mrs. Ella Mae Williams		ADDRESS 2217 Clifton Avenue	
19. CAUSE OF DEATH E765X1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Gunshot wound of head ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) STREET	
22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 4400 block of Park Heights Avenue		22D. TIME OF INJURY (APPROX.) Month 4 Day 4 Year 72 Hour 2:50 a.m.	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? Subject shot by unknown assailant.	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Peter Lipkovic, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
DATE SIGNED 4/8/72			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4-11-72	
24C. NAME OF CEMETERY or CREMATORY Arbutus mem. Park		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. APR 12 1972		25B. NAME OF REGISTRAR Robert E. Fisher, M.D.	
25C. FUNERAL DIRECTOR Arlington S. Phillips		ADDRESS 1727 N. Monroe Street	

75 03184

75 03184

RECEIVED

11

11

11

11

11

11

11

11

11

11

11

11

11

11

11

11

11

11

11

11

11

11

11

11

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

J-520		72 03525		BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		REG. NO. 72 03525	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) Jones, James E.				2. DATE AND HOUR OF DEATH 4. 6. 72 902 M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD						4. USUAL RESIDENCE (Where deceased lived. If institutions residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION 39		IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION Provident Hospital Complex 2600 Liberty Hgts. Ave. Baltimore, Md. 21215		A. STATE Maryland		B. COUNTY 1603		C. CITY OR TOWN Baltimore	
				D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		E. STREET AND NUMBER 1613 Edmondson Ave.			
5. SEX Male	6. RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 05-21-09	9. AGE (In years last birthday) 62	If Under 1 Yr. Months: Days: Hours: Mins.		If Under 24 Hrs. Mins.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Self Employed		10B. KIND OF BUSINESS OR INDUSTRY Unemployed		11. BIRTHPLACE (State or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME George L. Jones				14. MOTHER'S MAIDEN NAME Mary A. Arrington					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 216-10-2130		17. INFORMANT Edith Jones (Sister)		ADDRESS SAME			
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Pulmonary Embolism		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH few months			
				(B) DUE TO, OR AS A CONSEQUENCE OF: myocardial infarction		1 yr			
				(C)					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				GI Bleeding.		few weeks			
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from 3.13.1972 to 4.6.1972 that (I) (we) last saw the deceased alive on 4.6.1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE M. J. Shaf1				23B. DATE SIGNED 4/6/72		23C. PHYSICIAN'S NAME (Type) M. Shaf1, M. D.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4-10-72		24C. NAME of CEMETERY or CREMATORY Arbutus Mem. Park		24D. LOCATION Baltimore, Maryland		24E. CITY, town, or county (State)	
25A. DATE REC'D BY HEALTH DEPT. APR 12 1972		25B. NAME OF REGISTRAR Robert E. Taylor, R.D.		25C. FUNERAL DIRECTOR Arlington S. Phillips		25D. ADDRESS 1727 N. Monroe Street			



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 72 03526

BIRTH NO.

1. NAME OF DECEASED (Type or Print) JUANITA PURVIS		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> April 6, 1972 M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 2119 W. Mulberry Street		3. DATE PRONOUNCED DEAD Month Day Year Hour April 6, 1972 3:50 P. M.	
5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY 2002			
6. SEX Female	7. RACE Negro	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> Sep. DIVORCED <input type="checkbox"/>	C. CITY OR TOWN Baltimore
9. DATE OF BIRTH 2-18-21		10. AGE (In years lost birthday) 51	E. STREET AND NUMBER 2119 W. Mulberry Street
11. BIRTHPLACE (State or foreign country) South Carolina		12. CITIZEN OF WHAT COUNTRY? USA	13. FATHER'S NAME Levi Davis
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		14B. KIND OF BUSINESS OR INDUSTRY	15. MOTHER'S MAIDEN NAME Isabelle Pringle
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		17. SOCIAL SECURITY NO.	18. INFORMANT ADDRESS Mr. Charles Davis 512 Kauffman St. Phila., Pa.
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Widely disseminated neoplasm (primary site undetermined) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) (Inquiry)			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
22D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?			
23. I certify that I held on <u>Inquiry</u> <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <u>Charles S. Springate</u> M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) <u>Charles S. Springate, M.D.</u> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <u>April 7, 1972</u> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4-12-72	
24C. NAME OF CEMETERY or CREMATORY Arbutus Mem. Park		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. APR 12 1972		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.	
25C. FUNERAL DIRECTOR Arlington S. Phillips		25D. ADDRESS 1727 N. Monroe Street	

B260

BALTIMORE CITY HEALTH DEPARTMENT

72 03527

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 72 03527

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

ERNEST J. BOOKER

2. DATE
OF
DEATHKnown ☐ Estimated ☐

Month

Day

Year

Hour

M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL
OR INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

00 639 Dolphin Street

3. DATE

Month

Day

Year

Hour

M.

PRONOUNCED DEAD April 5, 1972

9:25 A.

5. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)

A. STATE Maryland

B. COUNTY

1703

6. SEX

Male

7. RACE

Negro

8. MARRIED ☐NEVER MARRIED ☐WIDOWED ☐DIVORCED ☐

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒ NO ☐

9. DATE OF BIRTH

Mar. 21, 1905

10. AGE (In years
last birthday)

67

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

E. STREET AND NUMBER

639 Dolphin Street

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

14. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Retired Steel Worker

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

no

17. SOCIAL
SECURITY NO.

213-07-9200 Laura Booker

18. INFORMANT

Same

19.

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART I (A).

CAUSE OF DEATH

Arteriosclerotic cardiovascular disease

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

MEDICAL CERTIFICATION

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

no

22A. EXTERNAL CAUSE WAS
UNDERLYING ☐ OR CONTRIB-
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg., etc.)22C. WHERE DID (if in Baltimore City, give exact location)
INJURY OCCUR?22D. TIME (Month) (Day) (Year) (Hour)
OF INJURY
(APPROX.)

22E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Ronald N. Kornblum, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

4/7/72

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

4-11-72

24C. NAME OF CEMETERY or CREMATORY

Arbiter's Man Park Arbiter's

24D. LOCATION (City, town, or county) (State)

Baltimore Md.

25A. DATE REC'D BY HEALTH DEPT.

APR 12 1972

25B. NAME OF REGISTRAR

Robert E. Farber M.D.

25C. FUNERAL DIRECTOR

Edmund O. Wilson

ADDRESS

1400 Bantley

2001 55 2001 55 2001 55

✓

2001 11 2001 11

1000 1000 1000 1000

11

2001 11 2001 11 2001 11

2001 11 2001 11

2001 11 2001 11 2001 11

2001 11 2001 11 2001 11

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

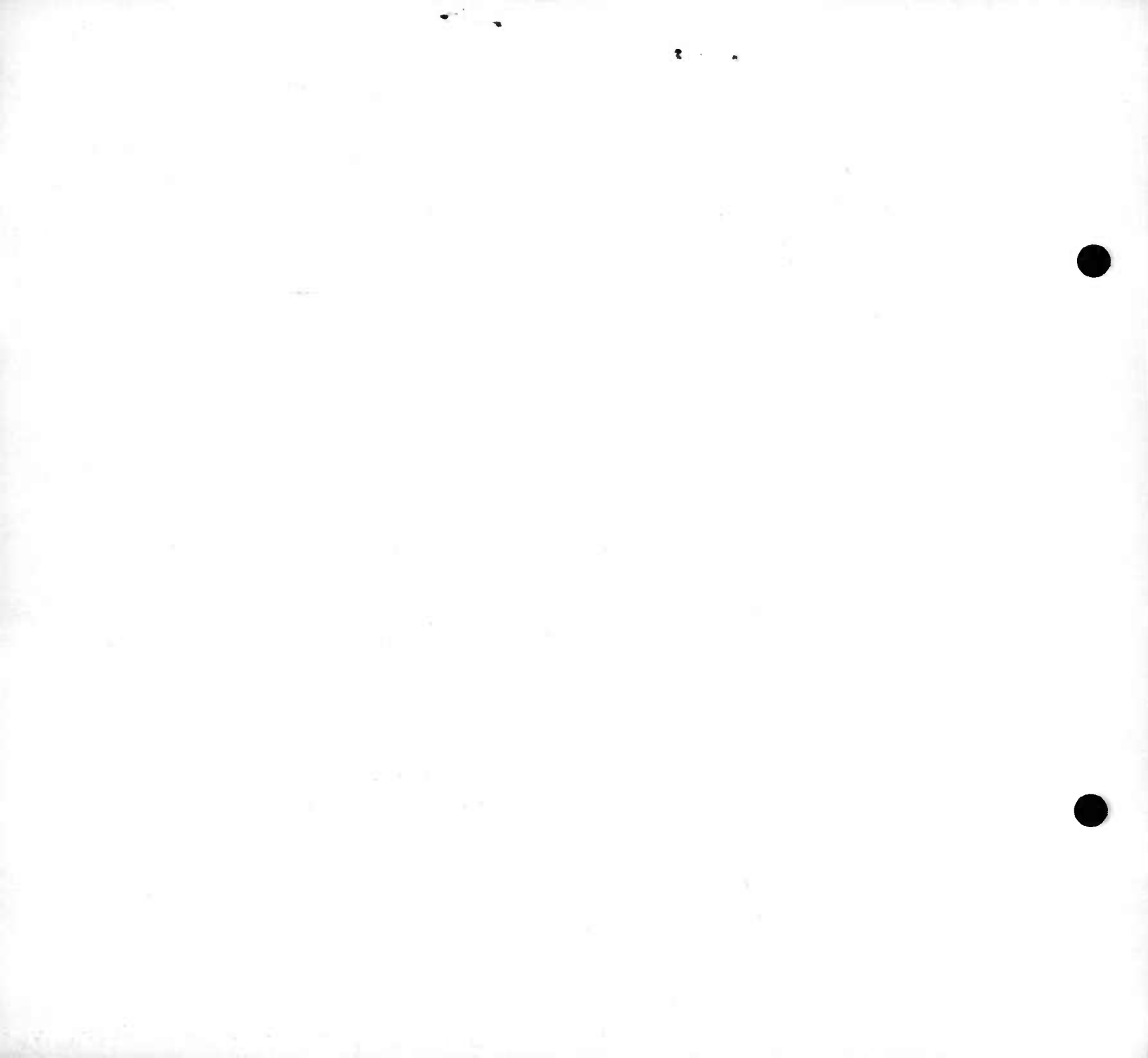
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 03528	
BIRTH NO. 72 03528		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) Joseph McCray		2. DATE AND HOUR OF DEATH April 8, 1972 10:40 A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY Baltimore			
FULL NAME OF HOSPITAL OR INSTITUTION 39 Provident Hospital		C. CITY OR TOWN 0		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER 1663 Hanson Ct.					
5. SEX Male	6. RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 03-10-84	9. AGE (In years last birthday) 88
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10B. KIND OF BUSINESS OR INDUSTRY Longshoreman		11. BIRTHPLACE (State or foreign country) Georgia	
12. CITIZEN OF WHAT COUNTRY U S A					
13. FATHER'S NAME Frank McGray		14. MOTHER'S MAIDEN NAME ????			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 70507-4088		17. INFORMANT Mrs Bernice Coston, 1667 Vincent Cou	
18. I		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE Pneumonia DUE TO, OR AS A CONSEQUENCE OF:			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF:			
(C) DUE TO, OR AS A CONSEQUENCE OF:					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While <input type="checkbox"/> Work At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from March 23, 1972 to April 8, 1972 that (I) (we) last saw the deceased alive on April 8, 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (did not) view the body after death.					
23A. SIGNATURE Lewis B. Boone, M.D., DEGREE				23B. DATE SIGNED April 8, 1972	
23C. PHYSICIAN'S NAME (Type) Lewis B. Boone, M.D., DEGREE				23D. ADDRESS Provident Hospital	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4/14/72		24C. NAME OF CEMETERY OR CREMATORY Mt Auburn Cemetery	
24D. LOCATION Baltimore, Md					
25A. DATE REC'D BY HEALTH DEPT. APR 12 1972		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR Adolphus Halstead 1206 W North Ave	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 03529	
BIRTH NO. 72 03529		1. NAME OF DECEASED (Type or Print) WILLIE A. VAUGHN		2. DATE AND HOUR OF DEATH 4/8/72 11:43 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) MARYLAND GENERAL			A. STATE MARYLAND		B. COUNTY 1402
			C. CITY OR TOWN BALT.		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER 1141 FREMONT AVE		
5. SEX M	6. RACE N	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH P	9. AGE (In years last birthday) 65	10. Under 1 Yr. Months: Days: 11. Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) UNKNOWN		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) ?	
13. FATHER'S NAME UNKNOWN		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY? UNKNOWN	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) UNKNOWN		16. SOCIAL SECURITY NO. UNKNOWN		17. INFORMANT Chart ADDRESS	
18. 4/10/72 2509		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE acute myocardial infarction		4 days	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) arteriosclerotic cardiovascular disease			
		(C) chronic renal disease, diabetes mellitus			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input checked="" type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) 2		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? BLVD	
22. I certify that (I) (this hospital) attended the deceased from APRIL 4 19 72 to APRIL 8 19 72 that (I) (we) last saw the deceased alive on APRIL 8 19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Robert B. Whitney				23B. DATE SIGNED 4/8/72	
23C. PHYSICIAN'S NAME (Type) ROBERT B. WHITNEY				23D. ADDRESS MARYLAND GENERAL HOSPITAL	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4/15/72		24C. NAME OF CEMETERY OR CREMATORY MT Calvary Cemetery	
24D. LOCATION (City, town, or county) A A County Md		25A. DATE REC'D BY HEALTH DEPT. APR 12 1972		25B. NAME OF REGISTRAR Robert E. Taber, M.D.	
25C. FUNERAL DIRECTOR Adolphus Halstead		25D. ADDRESS 1206 W North Ave			



1
J-520

J-520

72 03530

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

72 03530

BIRTH NO.

REG. NO.

1. NAME OF DECEASED (Type or Print) Alma Jones		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month 4 Day 8 Year 72 Hour M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 00 2501 Edmondson Avenue		3. DATE PRONOUNCED DEAD Month 4 Day 8 Year 72 Hour 11:17 p.m.	
6. SEX female		7. RACE Negro	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Balto.	
9. DATE OF BIRTH 8-10-07		10. AGE (In years last birthday) 64 If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF U.S.A.	
13. FATHER'S NAME Thomas Dixon		14. MOTHER'S MAIDEN NAME Alberta Green	
15. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY 1605		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	
17. SOCIAL SECURITY NO.		18. INFORMANT Laura Merritt	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Arteriosclerotic cardiovascular disease (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____	
20A. DATE OF OPERATION 0		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) no			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?			
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?			
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE Peter Lipkovic, M.D. EXAMINER'S NAME (Type) Peter Lipkovic, M.D. DATE SIGNED 4/9/72			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4/13/72	
24C. NAME of CEMETERY or CREMATORY Mt Auburn Em Balto		24D. LOCATION (City, town, or county) (State) Md.	
25A. DATE REC'D BY HEALTH DEPT. APR 12 1972		25B. NAME OF REGISTRAR James E. Taylor, M.D.	
25C. FUNERAL DIRECTOR Rayner Sanders		25D. ADDRESS 217 E. Preston	

05250 8

05250 8

James M. Smith
All rights reserved
Copyright 1914

James M. Smith
All rights reserved
Copyright 1914

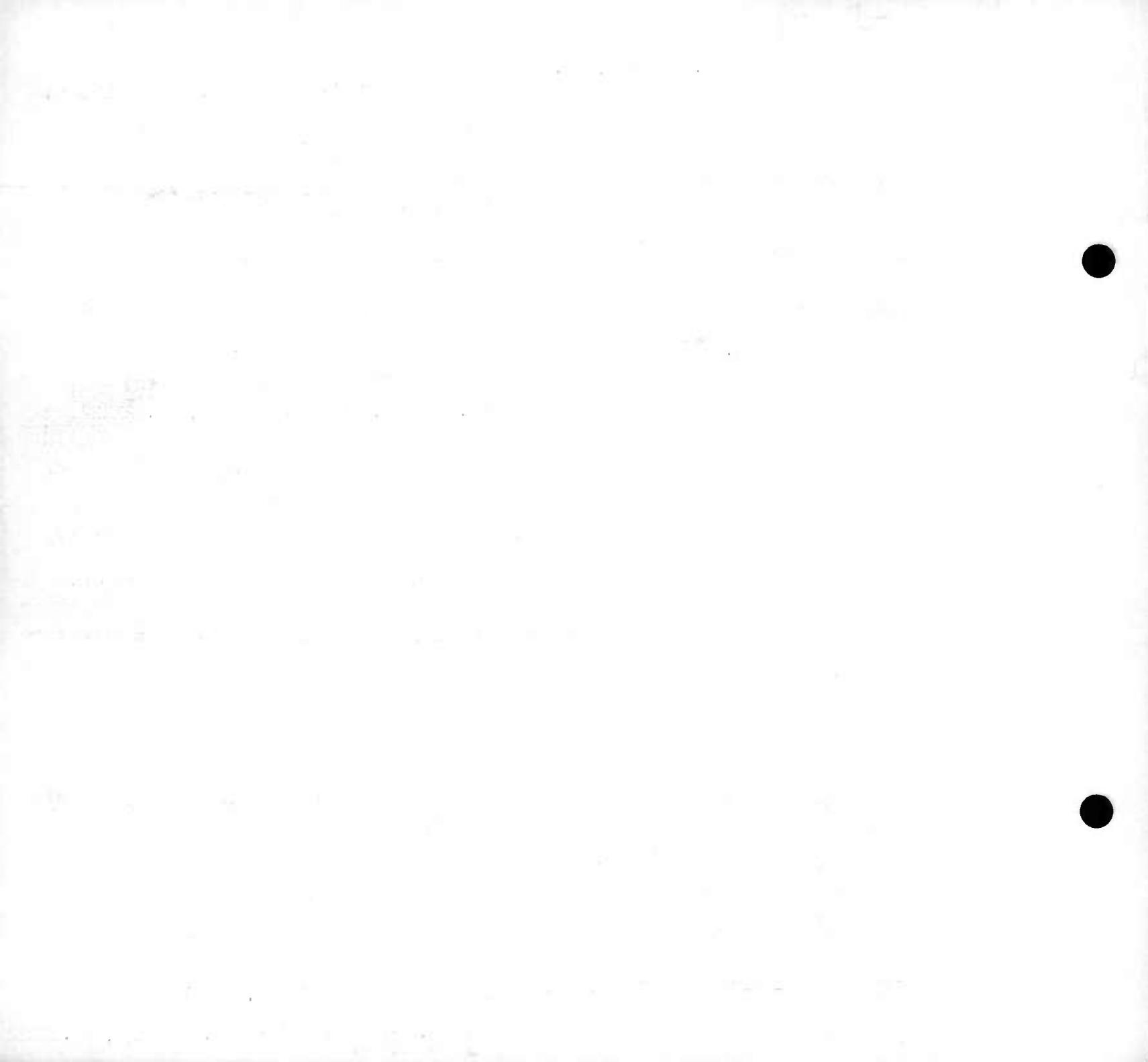
ADDITIONAL
COPIES
FOR
LIBRARY
OF
CONGRESS

James M. Smith
All rights reserved
Copyright 1914

FUNERAL DIRECTOR: IMPORTANT

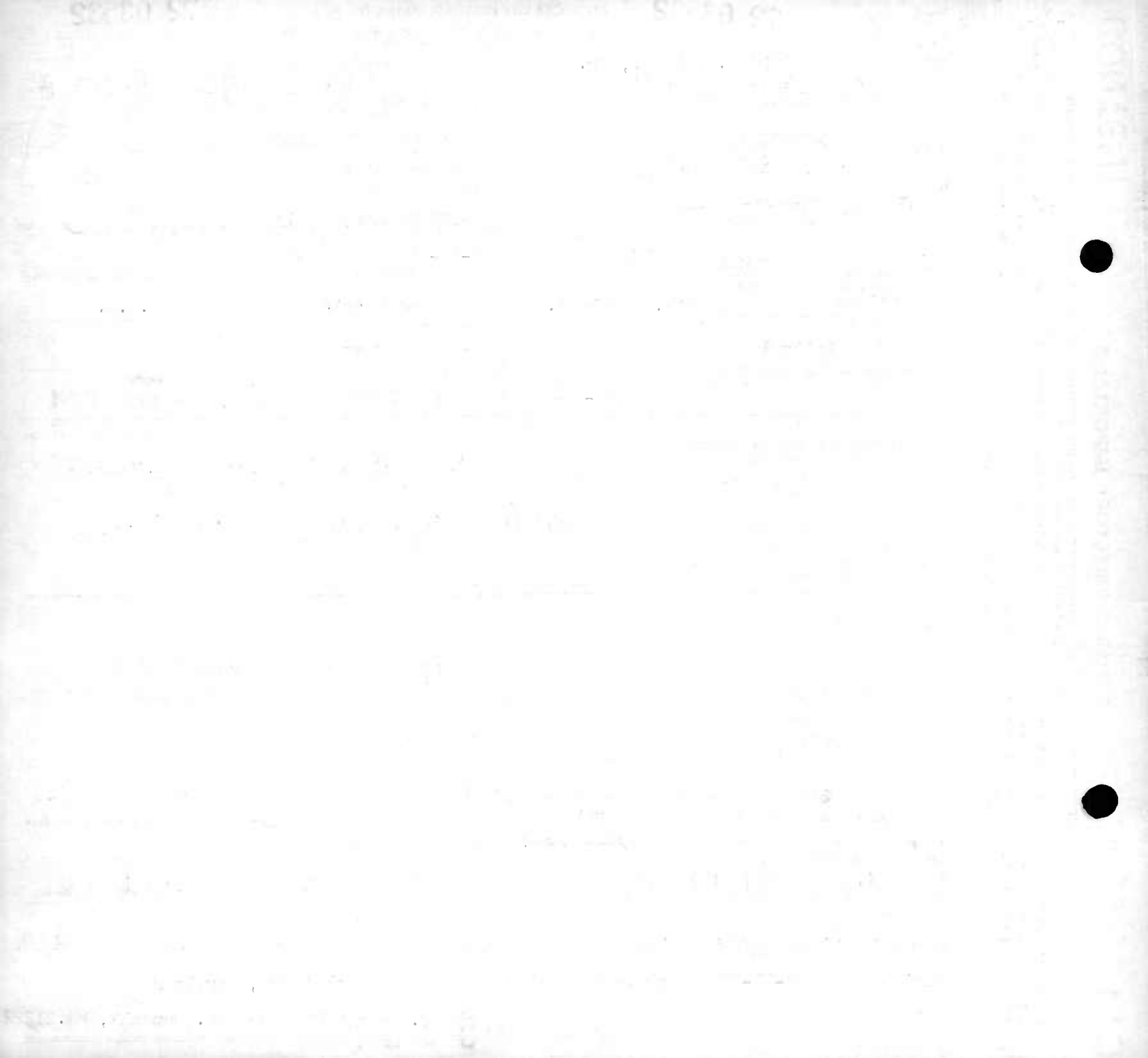
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-650 72 03531		BALTIMORE CITY HEALTH DEPARTMENT	
BIRTH NO.		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) Edward J. Birrane, Sr. EDWARD BIRRANE		2. DATE AND HOUR OF DEATH APRIL 8, 1972 3:30 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 35 CHURCH HOME AND HOSPITAL		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD. B. COUNTY Baltimore	
5. SEX Male		6. RACE White	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 02-16-11	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LETTER CARRIER		11. BIRTHPLACE (State or foreign country) MARYLAND	
13. FATHER'S NAME John C. Birrane		14. MOTHER'S MAIDEN NAME Eva Hartman	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 911-19-1336	
17. INFORMANT Wife:		ADDRESS 7452 Berkshire Road	
		Mrs. Mary A. Birrane Dundalk, Md. 21222	
18. 43501925019 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
(A) IMMEDIATE CAUSE CVA & Subarachnoid Hemorrhage		ONE MONTH.	
DUE TO, OR AS A CONSEQUENCE OF: AND LEFT HEMIPLEGIA			
(B) HYPERTENSION		SEVERAL YRS.	
DUE TO, OR AS A CONSEQUENCE OF:			
(C) ASCVD, DIABETES MELLITUS		UNKNOWN.	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). PNEUMONIA, URINARY TRACT INFECTION		3 WEEKS	
19A. DATE OF OPERATION 3-11-1972		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED TRACHEOSTOMY	
20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (nately medical examined) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I certify that the this hospital attended the deceased from MARCH 6, 1972 to APRIL 8, 1972 that he we last saw the deceased alive on APRIL 8, 1972 and that in my our opinion death occurred on the date and hour and from the causes stated above. He We did did not view the body after death.			
23A. SIGNATURE Rustum Irani		23B. DATE SIGNED April 8, 1972	
23C. PHYSICIAN'S NAME (Type) RUSTUM IRANI		23D. ADDRESS CHURCH HOME AND HOSPITAL	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4-11-72	
24C. NAME OF CEMETERY or CREMATORY Holy Redeemer Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. APR 12 1972		25B. NAME OF REGISTRAR John J. Duda	
25C. FUNERAL DIRECTOR John J. Duda		ADDRESS 7922 Wise Ave. Dundalk, Md. 21222	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

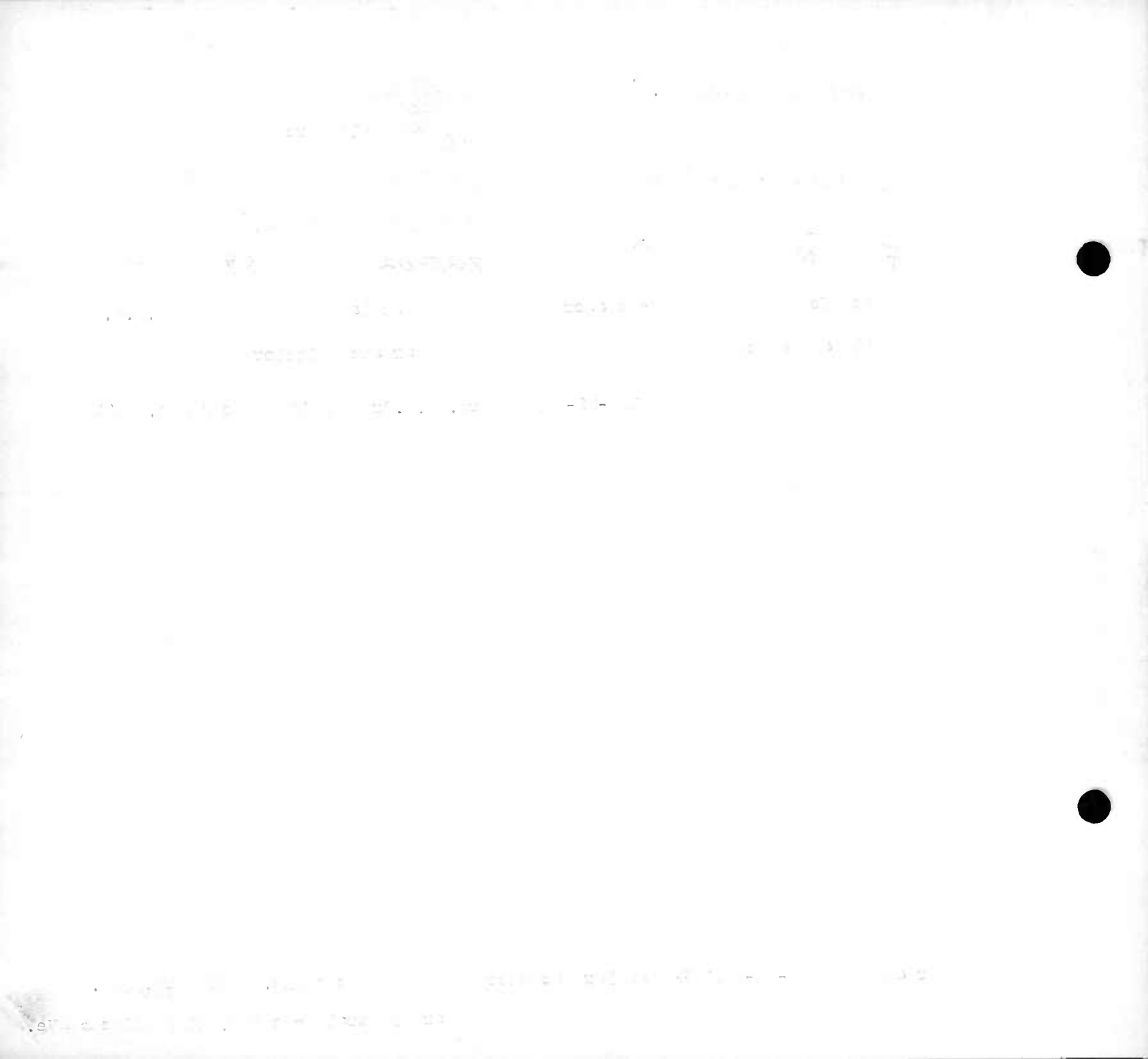
BALTIMORE CITY HEALTH DEPARTMENT				72 03532	
CERTIFICATE OF DEATH				REG. NO.	
BIRTH NO. <u>1-324</u>		1. NAME OF DECEASED (Type or Print) <u>Alvin A. Leitzel, Sr.</u>		2. DATE AND HOUR OF DEATH <u>8 APRIL 1972 7:30 A.M.</u>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if in institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>BALTO. CITY HOSPITALS</u> <u>4940 Eastern Avenue</u> <u>Baltimore, Maryland 21224</u>			<u>Maryland Baltimore</u> C. CITY OR TOWN <u>Sparrows Point</u> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER <u>1119 H Street 21219</u>		
5. SEX <u>Male</u>	6. RACE <u>Caucasian</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <u>WIDOWED</u> <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6-27-91</u>	9. AGE (In years last birthday) <u>80</u>	10. Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Beth. Steel Co.</u>		11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>	
13. FATHER'S NAME <u>Frederick Leitzel</u>		14. MOTHER'S MAIDEN NAME <u>Mary Hoffman</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>213-07-7990A</u>		17. INFORMANT <u>BCH: RECORDS</u> ADDRESS <u>4940 Eastern Avenue Baltimore, Maryland 21224</u>	
18. CAUSE OF DEATH					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <u>CARDIO-RESPIRATORY ARREST</u>					<u>IMMEDIATE</u>
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Atherosclerotic cardiovascular disease</u>					<u>2 YEARS</u>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from <u>7/3/71</u> 19 <u>71</u> to <u>8 APRIL</u> 19 <u>72</u> that (1) <u>last</u> saw the deceased alive on <u>8 APRIL</u> 19 <u>72</u> and that in (my) <u>last</u> opinion death occurred on the date and hour and from the causes stated above. (1) <u>(did)</u> (did not) view the body after death.					
23A. SIGNATURE <u>John J. Chabalko, M.D.</u>				23B. DATE SIGNED <u>8 April 1972</u>	
23C. PHYSICIAN'S NAME (Type) <u>John J. Chabalko, M.D.</u>				23D. ADDRESS <u>Baltimore City Hospitals</u> <u>4940 Eastern Avenue Baltimore, Maryland 21224</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>4-11-72</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Oak Lawn Cemetery</u>	
24D. LOCATION <u>Baltimore, Maryland</u>		25A. DATE REC'D BY HEALTH DEPT. <u>APR 12 1972</u>			
25B. NAME OF REGISTRAR <u>John E. Kelly, Jr.</u>		25C. FUNERAL DIRECTOR <u>John J. Duda</u> ADDRESS <u>7922 Wise Ave. Dundalk, Md. 21222</u>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

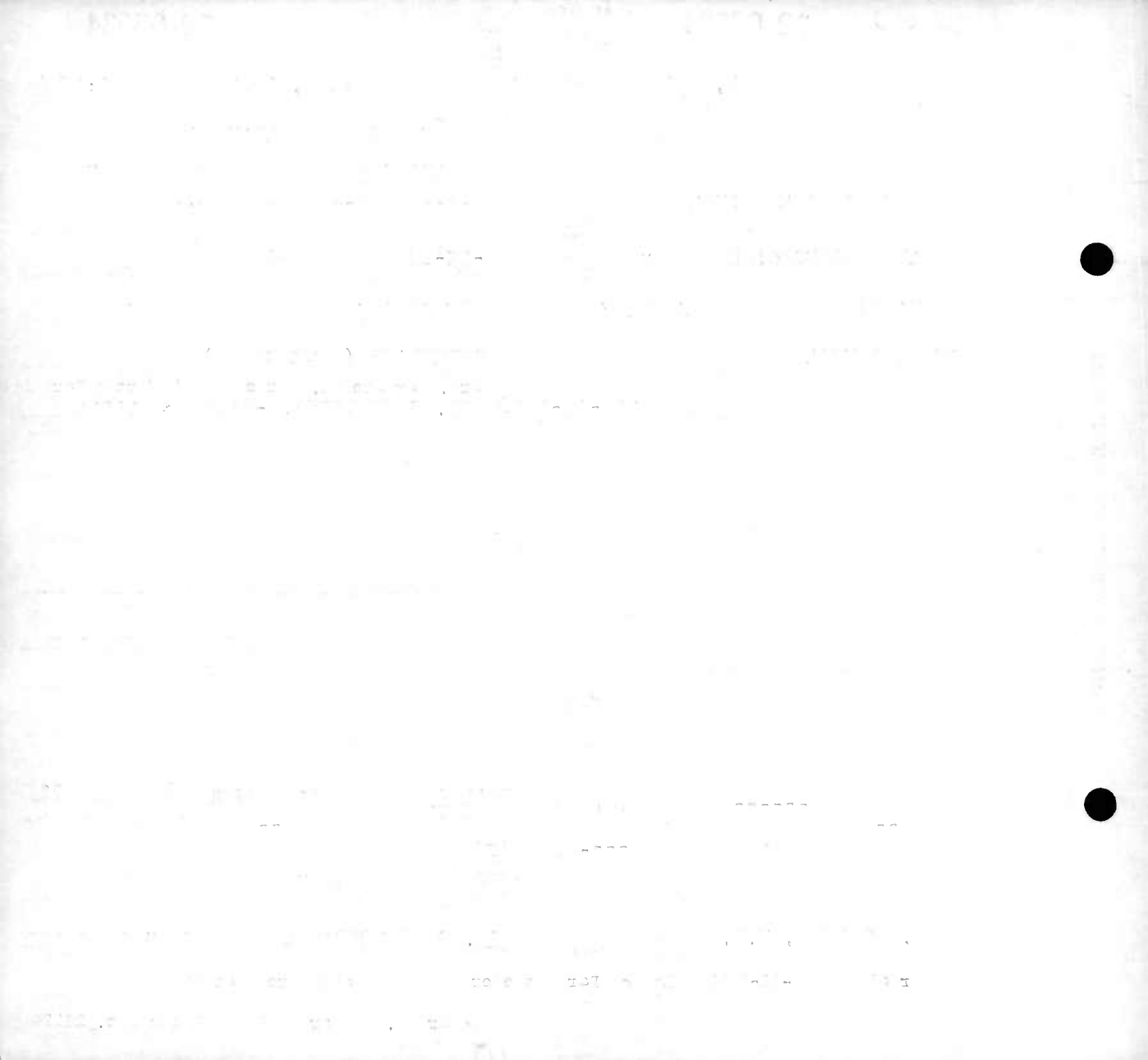
BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. <u>72 03533</u>	
1. NAME OF DECEASED (Type or Print) <u>Webster, Eva M.</u>		2. DATE AND HOUR OF DEATH <u>April 7, 1972</u> <u>3:10 P.M.</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>Sinai Hosp. of Baltimore INC.</u>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Md.</u> B. COUNTY <u>Baltimore</u> C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>490 BRUNSWICK ST.</u>			
5. SEX <u>F</u>	6. RACE <u>N</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-25-02</u>	9. AGE (in years last birthday) <u>69</u>	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Homemaker</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
13. FATHER'S NAME <u>William Dailey</u>		14. MOTHER'S MAIDEN NAME <u>Margaret Rittler</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>214-22-4650</u>		17. INFORMANT ADDRESS <u>Mrs. H.R. Grimm 5023 Wilkens Ave. 21228</u>	
18. CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshtemia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) IMMEDIATE CAUSE <u>Congestive Heart Failure</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>Chronic Lung disease</u> DUE TO, OR AS A CONSEQUENCE OF: (C) <u>Cancer of breast</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>several yrs.</u> <u>several yrs.</u>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (nally medical examined) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) <u>(this hospital)</u> attended the deceased from <u>April 5</u> 19 <u>72</u> to <u>April 7</u> 19 <u>72</u> that <u>(I)</u> <u>(we)</u> last saw the deceased alive on <u>April 7</u> 19 <u>72</u> and that <u>(n)</u> <u>(my)</u> <u>(our)</u> opinion death occurred on the date and hour and from the causes stated above. <u>(I)</u> <u>(We)</u> <u>(did)</u> <u>(did not)</u> view the body after death.					
23A. SIGNATURE <u>Jack Orlick</u> <u>M.D.</u> DEGREE				23B. DATE SIGNED <u>April 7, 1972</u>	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>4-11-1972</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Loudon Park Cemetery</u>	
24D. LOCATION (City, town, or county) (State) <u>Wilkens Ave. Baltimore, Md.</u>		25A. DATE REC'D BY HEALTH DEPT. <u>APR 12 1972</u>			
25B. NAME OF REGISTRAR <u>Robert E. Kelly, M.D.</u>		25C. FUNERAL DIRECTOR <u>Hubbard Funeral Home INC.</u>		25D. ADDRESS <u>4107 Wilkens Ave.</u>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>72 03534</u>	
BIRTH NO. <u>4-400</u>		72 03534		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) HEIL, REINHARD FRANCIS			2. DATE AND HOUR OF DEATH APRIL 8, 1972 1:20 A.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) ST AGNES HOSPITAL			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER 1412 FOREST PARK AVENUE		
5. SEX MALE	6. RACE CAUCASIAN	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-25-85	9. AGE (In years last birthday) 86	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED		10B. KIND OF BUSINESS OR INDUSTRY JEWELRY		11. BIRTHPLACE (State or foreign country) NEW JERSEY	
13. FATHER'S NAME CHARLES HEIL			14. MOTHER'S MAIDEN NAME CATHERINE (BALZER)		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 219-30-2028		17. INFORMANT Mrs. Margaret C. Hurdell, 1412 Forest Park Ave. ST. AGNES RECORDS-BALTO MD 21229	
18. 486X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Respiratory arrest ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Pneumonia			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH? <input type="checkbox"/> Notify medical examiner		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from APRIL 6 1972 to APRIL 8 1972 that (I) (we) last saw the deceased alive on APRIL 8 1972 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>E. Ramero MD</i>			23B. DATE SIGNED 4-8-72		23C. PHYSICIAN'S NAME (Type) E. RAMERO, M.D.
24A. BURIAL CREMATION, REMOVAL (Specify) Burial			24B. DATE 4-11-1972		24C. NAME OF CEMETERY or CREMATORY Loudon Park Cemetery
25A. DATE REC'D BY HEALTH DEPT. APR 12 1972			25B. NAME OF REGISTRAR Howard H. Hubbard		25C. FUNERAL DIRECTOR ADDRESS 4107 Wilkens Ave. 21229
24D. LOCATION (City, town, or county) (State) Baltimore, Maryland					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-642 72 03535				BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 03535	
BIRTH NO.				1. NAME OF DECEASED (Type or Print) BARLAG, MARGARET ETHEL			
2. DATE AND HOUR OF DEATH APRIL 7, 1972 1 2:45 P. M.				3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 40 ST AGNES HOSPITAL			
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY 2005				C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
E. STREET AND NUMBER 2418 CHRISTIAN STREET 21223				5. SEX FEMALE 6. RACE CAUCASIAN 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH 03/31/19				9. AGE (In years lost birthday) 32 53			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10B. KIND OF BUSINESS OR INDUSTRY			
11. BIRTHPLACE (State or foreign country) MARYLAND				12. CITIZEN OF WHAT COUNTRY? U S A			
13. FATHER'S NAME STOVENS, WILLIAM Stephens				14. MOTHER'S MAIDEN NAME XXXXXXXXXX Antonia Hanzlik			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. 218 055595			
17. INFORMANT BALTIMORE, MD. 21229				ADDRESS ST AGNES RECORDS, WILKENS & CATON AVES			
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). (A) IMMEDIATE CAUSE CARCINOMA - PANCREAS DUE TO, OR AS A CONSEQUENCE OF: W/ GENERALIZED METASTASES (B) DUE TO, OR AS A CONSEQUENCE OF: (C)				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY (Yes or No) X YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from FEBRUARY 24, 1972 to APRIL 7, 1972 that <input checked="" type="checkbox"/> (we) last saw the deceased alive on APRIL 7, 1972 and that <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) (did) (did not) view the body after death.							
23A. SIGNATURE Donato Vargas Jr.				23B. DATE SIGNED 4-8-72		23C. PHYSICIAN'S NAME (Type) DONATO VARGAS JR. M.D.	
23D. ADDRESS ST. AGNES HOSPITAL				24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4-11-1972	
24C. NAME of CEMETERY or CREMATORY Loudon Park Cemetery				24D. LOCATION (City, town, or county) (State) Baltimore, Maryland		25A. DATE REC'D BY HEALTH DEPT. APR 12 1972	
25B. NAME OF REGISTRAR Howard H. Hubbard				25C. FUNERAL DIRECTOR Howard H. Hubbard		ADDRESS 4107 Wilkens Avenue 21229	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

7-620 BIRTH NO.		72 03536		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 03536	
1. NAME OF DECEASED (Type or Print) JOSEPHINE F. FRISKEY (SMITH)				2. DATE AND HOUR OF DEATH April 8, 1972			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 2531			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 00 5011 Frederick Avenue Baltimore, Maryland 21229				C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER 5011 Frederick Avenue			
5. SEX Female	6. RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-9-1878	9. AGE (In years last birthday) 93	If Under 1 Yr. Months: Days:	If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Jacob Cassell				14. MOTHER'S MAIDEN NAME Josephine Anderson			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 216-07-6929		17. INFORMANT ADDRESS 21229 Mrs. Dorothy F. Lane, 5011 Frederick Ave.			
18. 794X1 CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: OLD AGE		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 93 yrs	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 19 34 to 19 72, that (I) (we) last saw the deceased alive on 2/25 19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Uberto Villasanta				23B. DATE SIGNED 4/10/72		23C. PHYSICIAN'S NAME (Type) Uberto Villasanta	
23D. ADDRESS University Hospital, Baltimore, Md.							
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4-11-1972		24C. NAME of CEMETERY or CREMATORY Loudon Park Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. APR 12 1972		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR Howard H. Hubbard		ADDRESS 4107 Wilkens Ave. 21229	

1900-5

1900-5 (1900) 1900-5

1900-5 1900-5 1900-5

1900-5 1900-5 1900-5

1900-5 1900-5 1900-5

1900-5 1900-5 1900-5

1900-5 1900-5 1900-5

1900-5

1900-5

1900-5

1900-5

1900-5

1900-5

1900-5

1900-5

1900-5

1900-5

1900-5

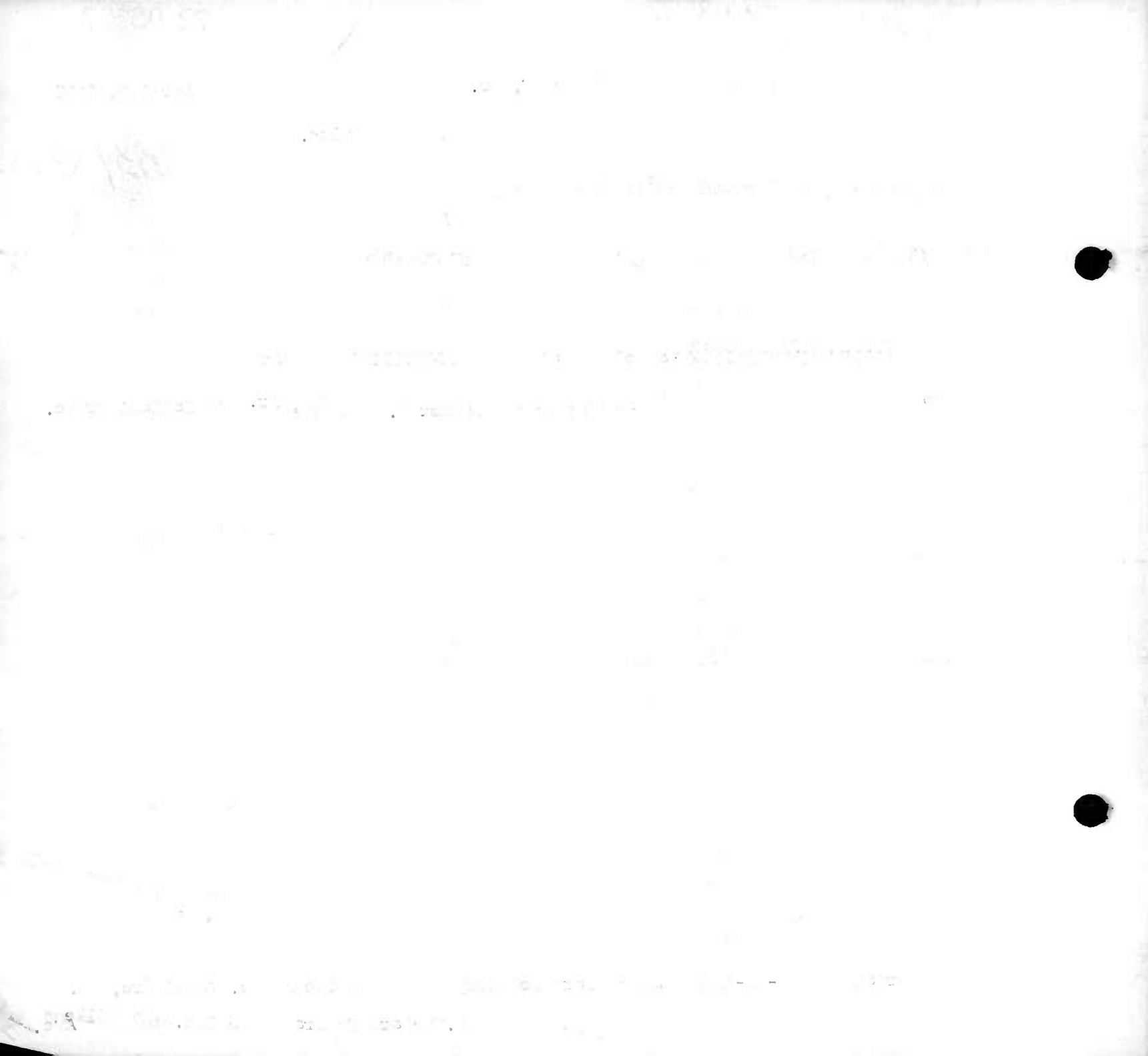
1900-5

1900-5

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

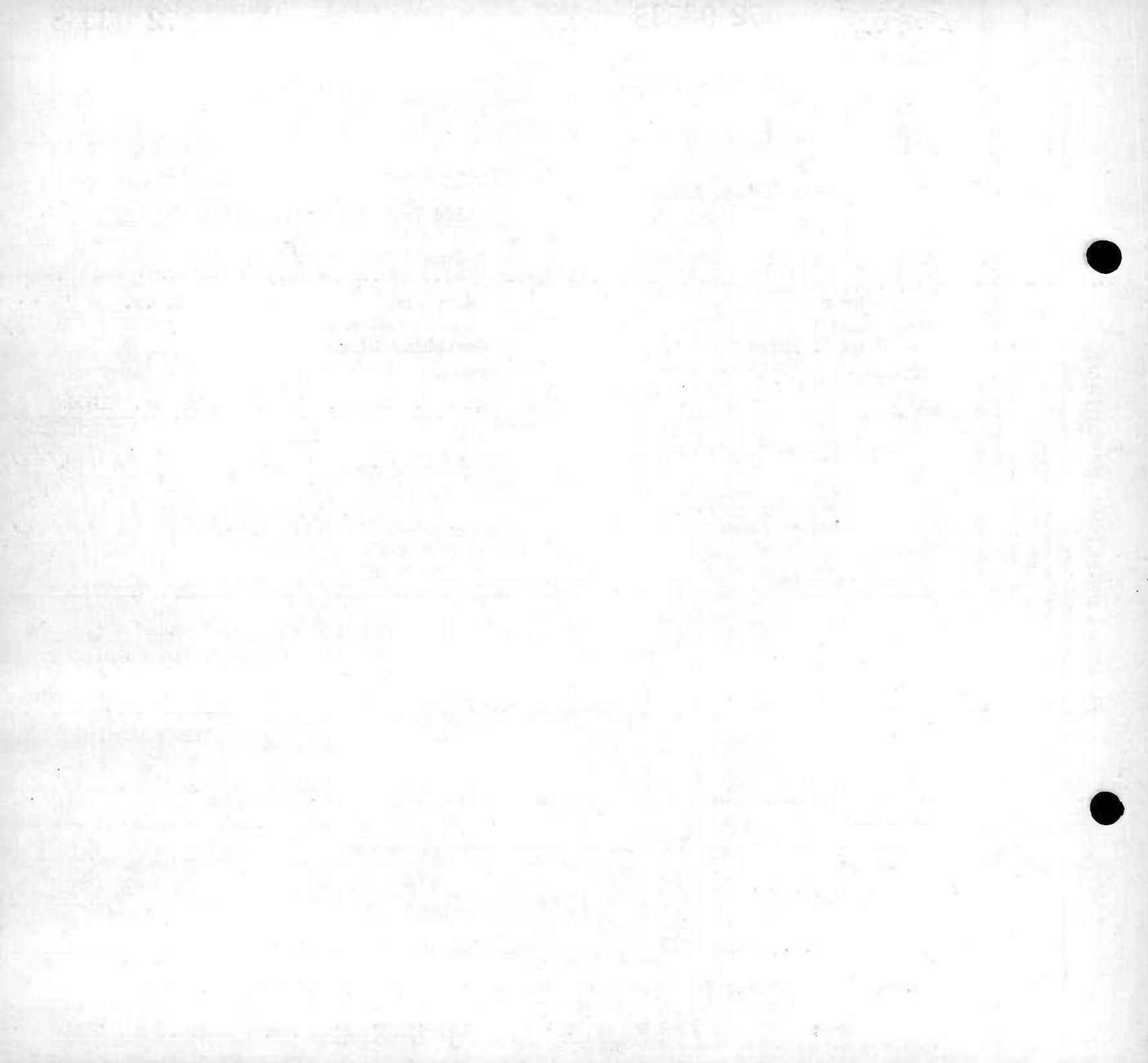
BIRTH NO. <u>D-140</u>		BALTIMORE CITY HEALTH DEPARTMENT 72 03537		72 03537	
DUVALL WALTER. CERTIFICATE OF DEATH				REG. NO. <u>7</u>	
1. NAME OF DECEASED (Type or Print) <u>DUVALL, WALTER H., Sr.</u>			2. DATE AND HOUR OF DEATH <u>8:30 A.M. April 8, 1972</u> M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>SOUTH BALTIMORE GEN. HOSPITAL</u>			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MD.</u> B. COUNTY <u>Balto.</u> C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>949, Palladi Dr.</u>		
5. SEX <u>Male</u>	6. RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5-20-90</u>	9. AGE (In years last birthday) <u>81</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Baltimore city fire dept.</u>			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>MD.</u>
12. CITIZEN OF WHAT COUNTRY? <u>America</u>			13. FATHER'S NAME <u>Daniel Duvall</u>		
14. MOTHER'S MAIDEN NAME <u>Sarah</u>			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u>		
16. SOCIAL SECURITY NO. <u>220-44-0506</u>			17. INFORMANT <u>Walter H. Duval¹¹, Jr.</u>		
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>427-01</u> <u>Congestive Cardiac Failure</u> <u>Generalized Anoxemia</u>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>4-7-72</u> 19 to <u>4-8-72</u> 19 that (I) (we) last saw the deceased alive on <u>4-7-72</u> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>P. Levy</u>			23B. DATE SIGNED <u>4-8-72</u>		23C. PHYSICIAN'S NAME (Type) <u>Dr. Levy</u>
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>			24B. DATE <u>4-11-1972</u>		24C. NAME of CEMETERY or CREMATORY <u>Loudon Park Cemetery</u>
24D. LOCATION (City, town, or county) (State) <u>Wilkins Ave. Baltimore, Md.</u>			25A. DATE REC'D BY HEALTH DEPT. <u>APR 12 1972</u>		
25B. NAME OF REGISTRAR <u>Robert E. Fisher, M.D.</u>			25C. FUNERAL DIRECTOR <u>H. Hubbard Funeral Home Inc.</u>		
25D. ADDRESS <u>4107 Wilkins Ave.</u>			25E. ADDRESS		



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

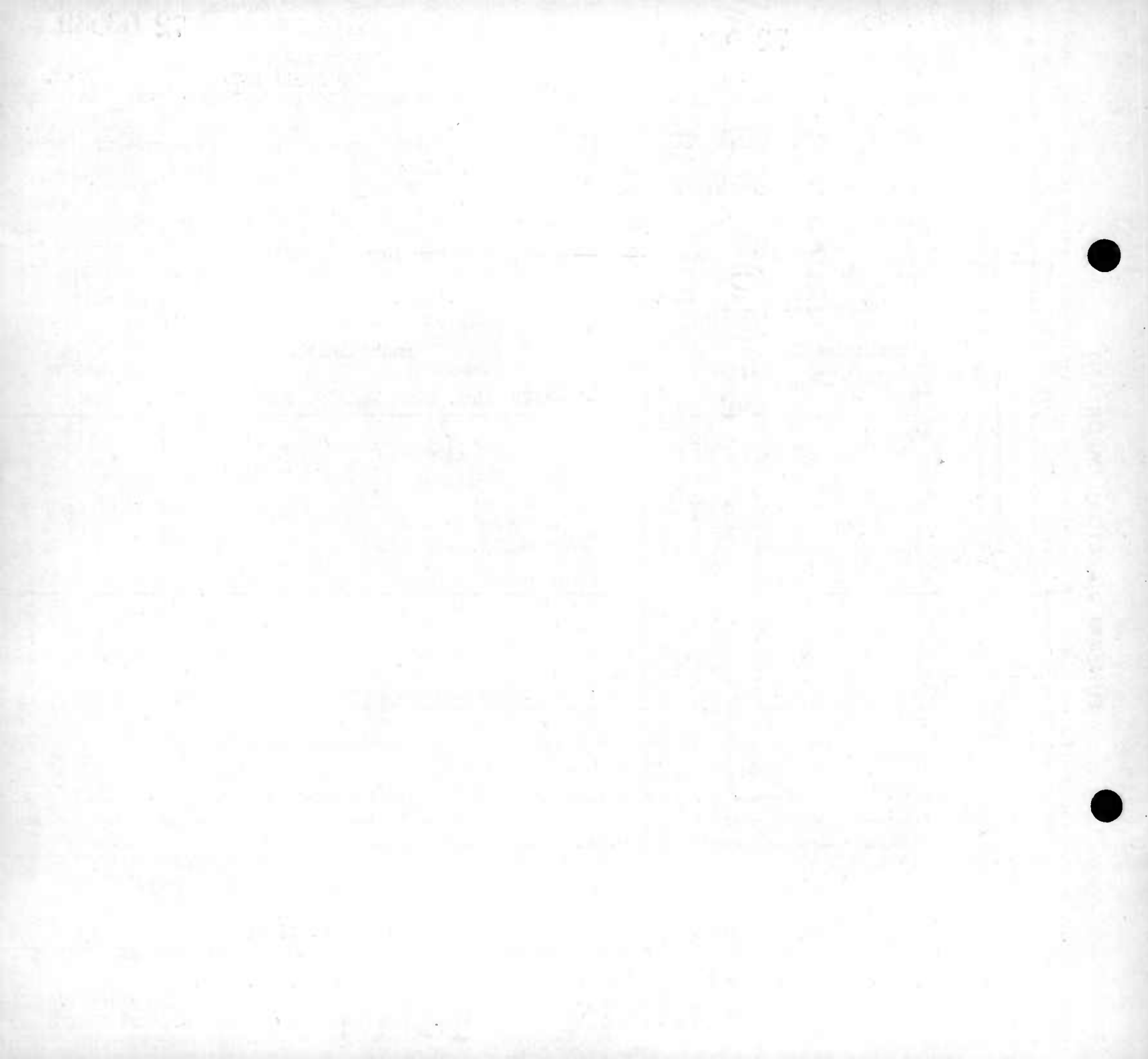
F-526 72 03538				BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 03538	
BIRTH NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH			
WILHEMLINA ENGERS				9 Apr. 72			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				A. STATE B. COUNTY			
4144 Parkside Drive. 21206				C. CITY OR TOWN		D. INSIDE CITY LIMITS?	
				Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER				4144 Parkside Drive 21206			
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH		9. AGE (In years last birthday)	If Under 1 Yr. Months: Days	If Under 24 Hrs. Hours: Min.
Female	Caucasian	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	5 June 1890		81		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
at home				Maryland		U.S.A.	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
John A. Engers				Josephine Streb			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS			
no		216-46-0518		Anne M. Engers, 4144 Parkside Dr. 21206			
18. CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)				6 months			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.				6 months			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				20 years			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
Sept. 1971		Cancer right breast		no			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					
22. I certify that (I) (this hospital) attended the deceased from July 14 1949 to April 9 1972 that (I) (we) lost saw the deceased alive on April 7 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE				23B. DATE SIGNED			
M.F. Polek, M.D.				4/10/72			
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
M.F. Polek MD				3603 Belair Rd. 21213			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
burial		12 Apr 72		Most Holy Redeemer Cemetery		Baltimore, Md. 21206	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS			
APR 12 1972		Ulrich Funeral Home, Balto., Md. 21206					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

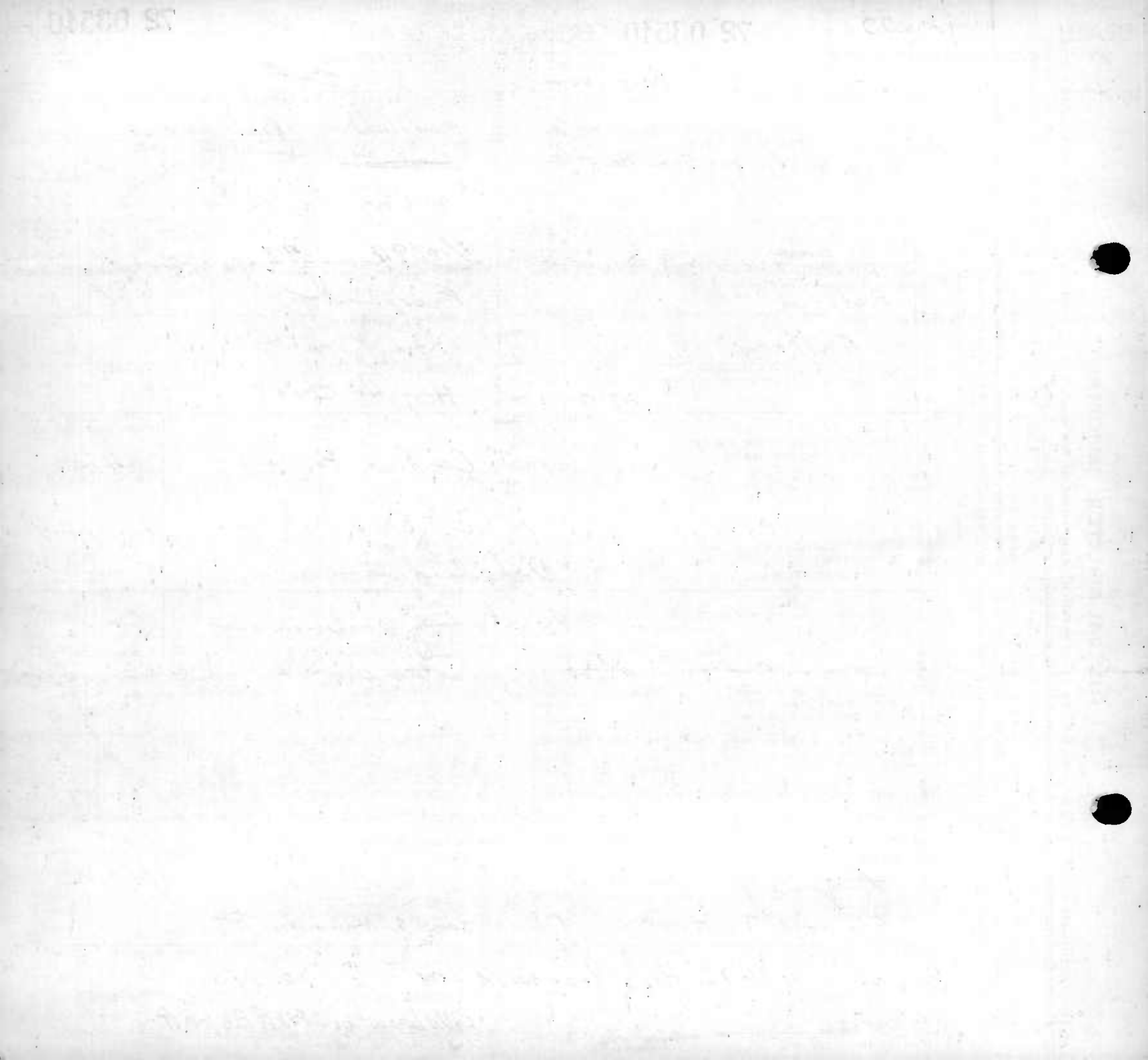
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 03539	
M-200 72 03539		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) MATT E. MAKI			2. DATE AND HOUR OF DEATH 9 April 1972		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 90 Harford Gardens Nursing Home			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY BALTO.		
			C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER 3021 Hiss Ave. 21234		
5. SEX Male	6. RACE Caucasian	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 15 Nov 1890	9. AGE (In years last birthday) 81	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) galvanizing mill		10B. KIND OF BUSINESS OR INDUSTRY Steel		11. BIRTHPLACE (State or foreign country) Finland	
12. CITIZEN OF WHAT COUNTRY? Finland			13. FATHER'S NAME unobtainable		
14. MOTHER'S MAIDEN NAME unobtainable			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		
16. SOCIAL SECURITY NO. 234-10-4179			17. INFORMANT Mrs. Elma Twardy, 3021 Hiss Ave. 21234		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) 412.41 Constrictive heart failure (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Arteriosclerotic C. V. Artery (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 days 10 yrs		
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
21A. DATE OF OPERATION 0		21B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21C. AUTOPSY? (Yes or No) No	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? (If in Baltimore City, give exact location)	
22. I certify that (I) (this hospital) attended the deceased from June 19 68 to April 9 19 72 , that (I) was lost saw the deceased alive on April 8 19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) was (did not) view the body after death.					
23A. SIGNATURE Loy M. Zimmerman, MD			23B. DATE SIGNED 4/11/72		
23C. PHYSICIAN'S NAME (Type) Loy M. Zimmerman, MD			23D. ADDRESS 3202 Harford Rd. 21218		
24A. BURIAL CREMATION, REMOVAL (Specify) burial		24B. DATE 12 Apr 72		24C. NAME OF CEMETERY or CREMATORY Oak Lawn Cemetery	
24D. LOCATION Balto. Co., Md.		24E. FUNERAL DIRECTOR Ulrich Funeral Home, Balto., Md. 21206			
25A. DATE REC'D BY HEALTH DEPT. APR 12 1972		25B. NAME OF REGISTRAR Robert E. Feltz		25C. ADDRESS Ulrich Funeral Home, Balto., Md. 21206	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

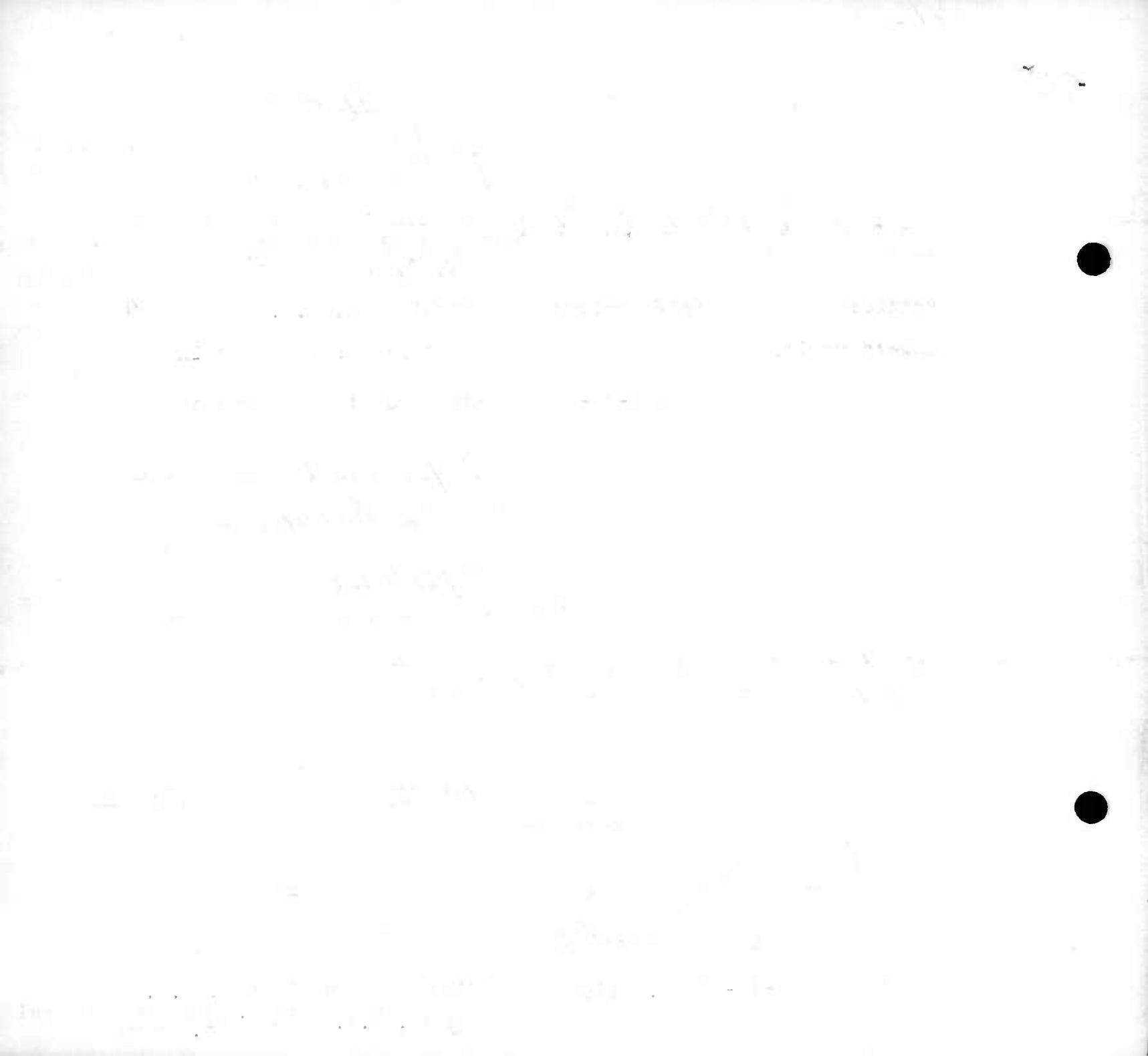
B-653		72 03540		BALTIMORE CITY HEALTH DEPARTMENT		X REG. NO.		72 03540	
1. NAME OF DECEASED (Type or Print) <i>Henry J. Borndorn</i>					2. DATE AND HOUR OF DEATH <i>50 4/9/72 5:55 A.M.</i>				
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <i>South Baltimore Gen Hosp</i> <i>43</i>					4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>Baltimore Co.</i> C. CITY OR TOWN <i>Linthicum</i> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <i>903 Wanda Rd</i>				
5. SEX <i>M</i>	6. RACE <i>Cauc</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>1/10/94</i>	9. AGE (In years last birthday) <i>78</i>	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired</i>			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		
13. FATHER'S NAME <i>Anthony</i>			14. MOTHER'S MAIDEN NAME <i>Rose Smith</i>			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>NO</i>			
16. SOCIAL SECURITY NO. <i>217-07-9861-A</i>			17. INFORMANT <i>Hospital Chart</i>			ADDRESS			
18. <i>412.4 I</i> CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 19A. DATE OF OPERATION <i>0</i> 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Resolving pneumonia</i> 20A. AUTOPSY (Yes or No) <i>No</i> 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>24 hrs</i> <i>many years</i> <i>7 month</i> <i>7 month</i>				
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from <i>3/17</i> 19 <i>72</i> to <i>4/9</i> 19 <i>72</i> , that (I) (we) last saw the deceased alive on <i>4/8</i> 19 <i>72</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Stanford J. Huber MD</i>			23B. DATE SIGNED <i>4/9/72</i>			23C. PHYSICIAN'S NAME (Type) <i>Stanford J. Huber MD</i>			
23D. ADDRESS <i>3001 S. Hanover St.</i>			24A. BURIAL CREMATION, REMOVAL (Specify) <i>BURIAL</i>						
24B. DATE <i>4-11-72</i>			24C. NAME OF CEMETERY or CREMATORY <i>Holy Redeemer Cem.</i>			24D. LOCATION (City, town, or county) (State) <i>Balto. Md.</i>			
25A. DATE REC'D BY HEALTH DEPT. <i>APR 12 1972</i>			25B. NAME OF REGISTRAR <i>B. Dabrowski</i>			25C. FUNERAL DIRECTOR <i>2818 E. Balto. St.</i>			
25D. ADDRESS			25E. ADDRESS						



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

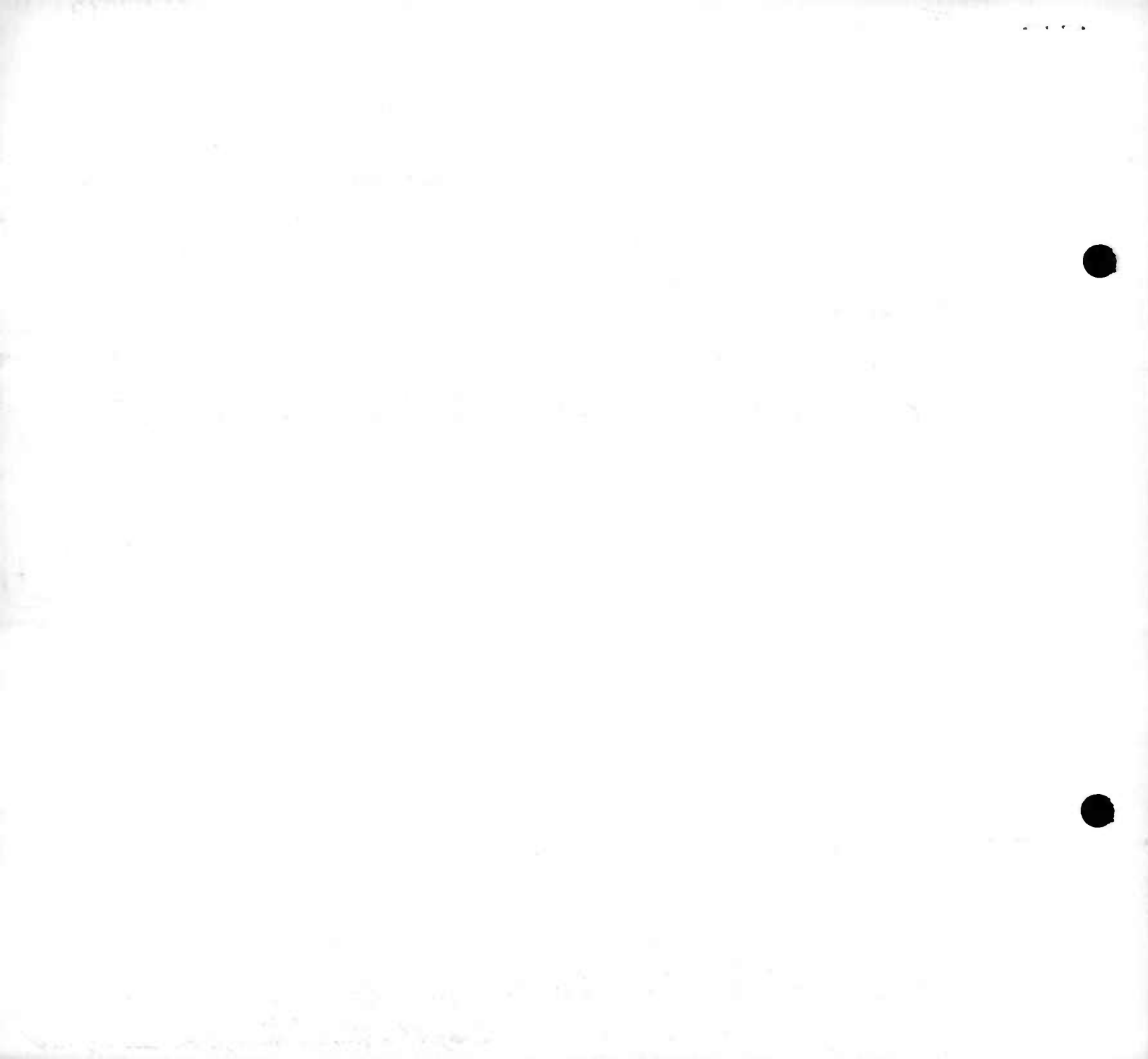
BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 03541	
U-623 BIRTH NO. 72 03541		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <i>Alphonse Urciolo</i>		2. DATE AND HOUR OF DEATH <i>4/5/72 3:15 P.M.</i>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>MD</i> B. COUNTY <i>Bethesda</i>	
FULL NAME OF HOSPITAL OR INSTITUTION <i>University of Maryland Hospital</i>		C. CITY OR TOWN <i>Bethesda, Md.</i> D. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		E. STREET AND NUMBER <i>Redwood & Greene STS - 6500</i>	
5. SEX <i>Male</i>	6. RACE <i>white</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>4/18/11</i>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Painter</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Self Employed</i>	9. AGE (in years last birthday) <i>60</i>
11. BIRTHPLACE (State or foreign country) <i>Washington, D.C.</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Angelo Urciolo</i>		14. MOTHER'S MAIDEN NAME <i>Antoinette Piserchin</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>NO</i>		16. SOCIAL SECURITY NO. <i>578-09-6893</i>	
17. INFORMANT <i>Mary Urciolo</i>		ADDRESS <i>Same as 4</i>	
18. <i>4/2/31</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Myocardial Infarction</i> <i>Left Ventricular Aneurysm</i> (B) DUE TO, OR AS A CONSEQUENCE OF: <i>Heart failure</i> (C) <i>Resection of Aneurysm c.p.b.</i>	
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
19A. DATE OF OPERATION <i>4/5/72</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Ventricular Aneurysm</i>	
20A. AUTOPSY (Yes or No) <input checked="" type="checkbox"/>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <i>3/20/72</i> 19 to <i>4/5/72</i> 19 that (I) (we) last saw the deceased alive on <i>4/5/72</i> 19 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <i>Vickie Hernandez</i>		23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) <i>Vickie Hernandez</i>		23D. ADDRESS <i>University Hospital</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>4-10-72</i>	
24C. NAME OF CEMETERY OR CREMATORY <i>Mt. Olivet Cemetery</i>		24D. LOCATION (City, town, or county) (State) <i>Washington, D.C.</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>APR 12 1972</i>		25B. NAME OF REGISTRAR <i>Robert A. Pumphrey</i>	
25C. FUNERAL DIRECTOR <i>Homes, B.A.</i>		25D. ADDRESS <i>Bethesda, Maryland</i>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

<div style="display: flex; justify-content: space-between;"> T-460 BALTIMORE CITY HEALTH DEPARTMENT </div> <div style="display: flex; justify-content: space-between;"> CERTIFICATE OF DEATH 72 03542 </div>		REG. NO. _____	
BIRTH NO. 72 03542		2. DATE AND HOUR OF DEATH 4/11/72 520 A M.	
1. NAME OF DECEASED (Type or Print) <u>ROGER EARL TAYLOR</u>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MD</u> B. COUNTY <u>ANN ARUNDEL</u>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>UNIV. HOSP 38</u>		C. CITY OR TOWN <u>Northham</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input checked="" type="checkbox"/>	
		E. STREET AND NUMBER <u>428 Cleveland Rd.</u>	
5. SEX M	6. RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1/11/27
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SUPERVISOR</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>EMERY FIBERS</u>	9. AGE (In years last birthday) 45
11. BIRTHPLACE (State or foreign country) <u>MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>EARL TAYLOR</u>		14. MOTHER'S MAIDEN NAME <u>MARTHA KNOPP</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>22016 5250</u>	17. INFORMANT <u>Mrs. June Taylor (wife)</u>
		ADDRESS <u>Same AS #4</u>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>CARDIAC ARREST</u> (B) <u>RESPIRATORY ARREST</u> DUE TO, OR AS A CONSEQUENCE OF: (C) <u>BRONCHIECTASIS</u>	
		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH (IMMED) (IMMED) CHRONIC	
MEDICAL CERTIFICATION			
19A. DATE OF OPERATION 0	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No) NO	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>4/10/72</u> 19 <u>4/11</u> 1972 that (I) (we) last saw the deceased alive on <u>4/11</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.			
23A. SIGNATURE <u>Robert A. Lessey</u>		23B. DATE SIGNED 4/11/72	23C. PHYSICIAN'S NAME (Type) <u>ROBERT A. LESSEY</u>
		23D. ADDRESS <u>UNIV. HOSP.</u>	23E. DEGREE
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>	24B. DATE <u>4/14/72</u>	24C. NAME OF CEMETERY OR CREMATORY <u>Glen Haven Mortuary</u>	24D. LOCATION (City, town, or county) (State) <u>Glen Burnie A.A. Md.</u>
25A. DATE REC'D BY HEALTH DEPT. <u>APR 12 1972</u>	25B. NAME OF REGISTRAR <u>John E. Taylor, MD</u>	25C. FUNERAL DIRECTOR <u>Signature of Funeral Home</u>	ADDRESS <u>Glen Burnie, Md.</u>



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 03543	
7-500 72 03543 CERTIFICATE OF DEATH					
BIRTH NO. 1. NAME OF DECEASED (Type or Print) CHARLES FINN				2. DATE AND HOUR OF DEATH APRIL 9, 1972 7:16 P.m.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) SINAI HOSPITAL 42				4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE MARYLAND B. COUNTY 2719 C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 5701 JONQUIL AVENUE #21215	
5. SEX MALE	6. RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH AUGUST 19, 1898	9. AGE (In years last birthday) 73	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SALESMAN		10B. KIND OF BUSINESS OR INDUSTRY INSURANCE		11. BIRTHPLACE (State or foreign country) TRENTON, NEW JERSEY	
13. FATHER'S NAME JOSEPH FINN			14. MOTHER'S MAIDEN NAME MARIE ?		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 221-07-9478A		17. INFORMANT MRS. BLANCHE FINN, 5701 JONQUIL AVE. #21215 ADDRESS	
18. CAUSE OF DEATH I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 years (A) IMMEDIATE CAUSE <i>Arteriosclerotic Cardiovascular Disease</i> DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <i>Diabetes</i>					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Nat While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>Jan 1962</i> to <i>April 1972</i> that (I) (we) last saw the deceased alive on <i>April 7</i> 19 <i>72</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Sheldon Goldgeier</i>				23B. DATE SIGNED <i>April 10, 1972</i>	
23C. PHYSICIAN'S NAME (Type) SHELDON GOLDGEIER				23D. ADDRESS 848 W. 36th STREET	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 4-11-72		24C. NAME of CEMETERY or CREMATORY MONTEFIORE	
		24D. LOCATION (City, town, or county) (State) PHILADELPHIA, PENNSYLVANIA			
25A. DATE REC'D BY HEALTH DEPT. APR 12 1972		25B. NAME OF REGISTRAR <i>Robert E. ...</i>		25C. FUNERAL DIRECTOR SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD ADDRESS	

1971, 1972

RECEIVED

RECEIVED

2301 JOURNAL AVENUE 23112

WASH DC 20540

THEODORE W. JERRY

MARIN

23112 JOURNAL AVENUE 23112

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

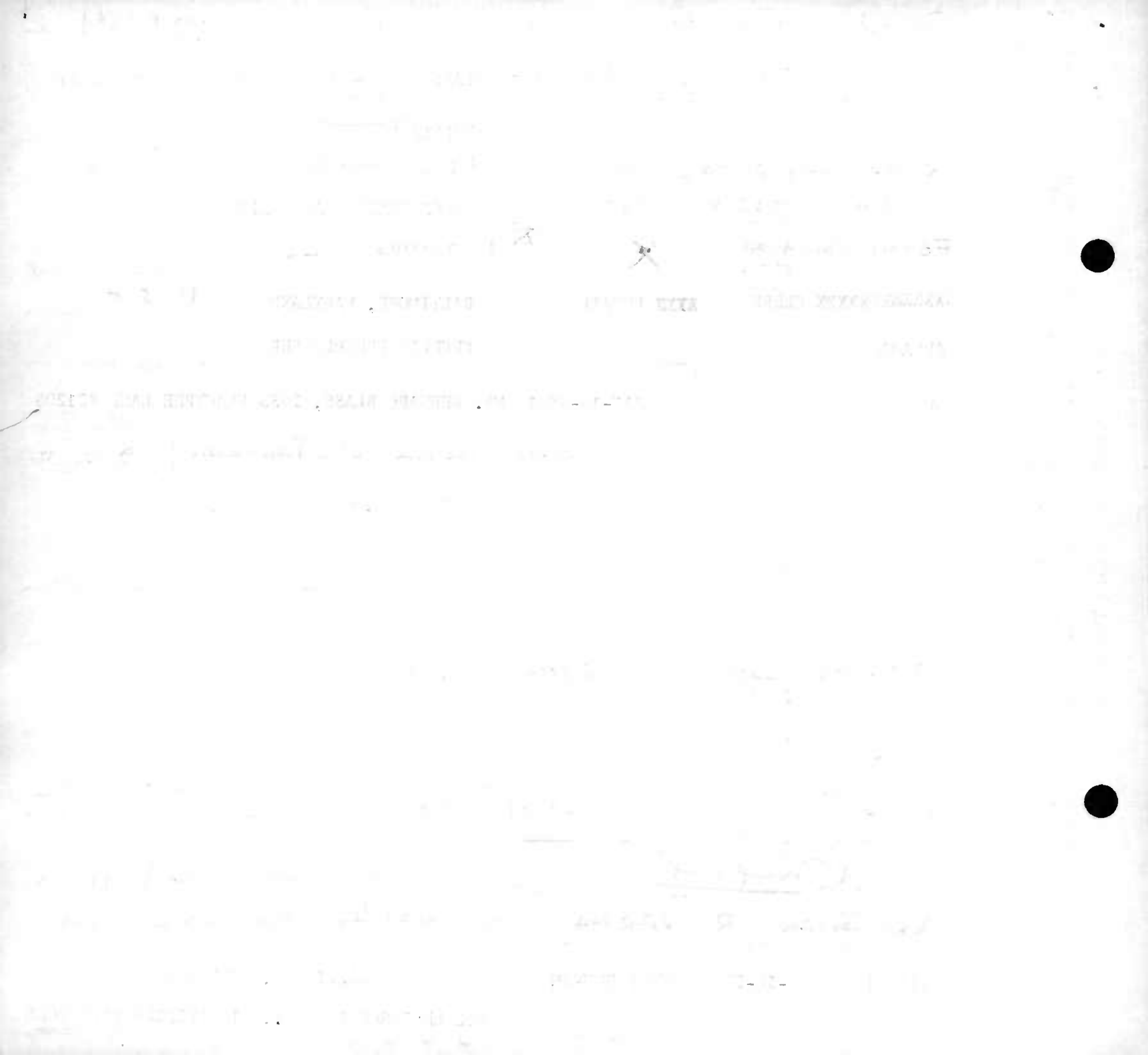
RECEIVED

RECEIVED

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				72 03544		72 03544	
T-460				72 03544		72 03544	
BIRTH NO.				1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
				THALER, SARAH BLASS		4/9/1972 5:40 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION SINAI HOSPITAL OF BALTIMORE INC.				A. STATE MARYLAND			
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				B. COUNTY BALTO			
				C. CITY OR TOWN BALTIMORE			
				D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
				E. STREET AND NUMBER 6665 SANZO ROAD #21209			
5. SEX FEMALE	6. RACE CAUCASIAN	7. MARRIED WIDOWED	NEVER MARRIED DIVORCED	8. DATE OF BIRTH 1-7-1903	9. AGE (In years last birthday) 69	10. Under 1 Yr. Months	11. Under 24 Hrs. Days
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) XXXXXXXXXX CLERK				10B. KIND OF BUSINESS OR INDUSTRY XXXX RETAIL		11. BIRTHPLACE (State or foreign country) BALTIMORE, MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U.S.A.				13. FATHER'S NAME ABRAHAM			
14. MOTHER'S MAIDEN NAME CECELIA FREEDLANDER				15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO			
16. SOCIAL SECURITY NO. 217-18-5891				17. INFORMANT MR. BERNARD BLASS, 1033 FLAGTREE LANE #21208			
18. CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CARCINOMA OF PANCREAS (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: WITH EXTENSIVE METASTASES (B) DUE TO, OR AS A CONSEQUENCE OF: (C)			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).							
19A. DATE OF OPERATION 1/24/72		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED LAPAROTOMY AND BIASY		20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (A) (this hospital) attended the deceased from 3-2-1972 to 4-9-1972 that (I) (we) last saw the deceased alive on 4/9/1972 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE 				23B. DATE SIGNED 4/9/72		23C. PHYSICIAN'S NAME (Type) KRISHNAN. R. VARMA	
23D. ADDRESS % SINAI HOSPITAL, BALTIMORE				24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL			
24B. DATE 4-10-72				24C. NAME OF CEMETERY or CREMATORY ANSHE EMUNAH			
24D. LOCATION BALTIMORE, MARYLAND				25A. DATE REC'D BY HEALTH DEPT. APR 12 1972			
25B. NAME OF REGISTRAR J. J. J. J.				25C. FUNERAL DIRECTOR SQL LEVINSON & BROS., 6010 REISTERSTOWN ROAD			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

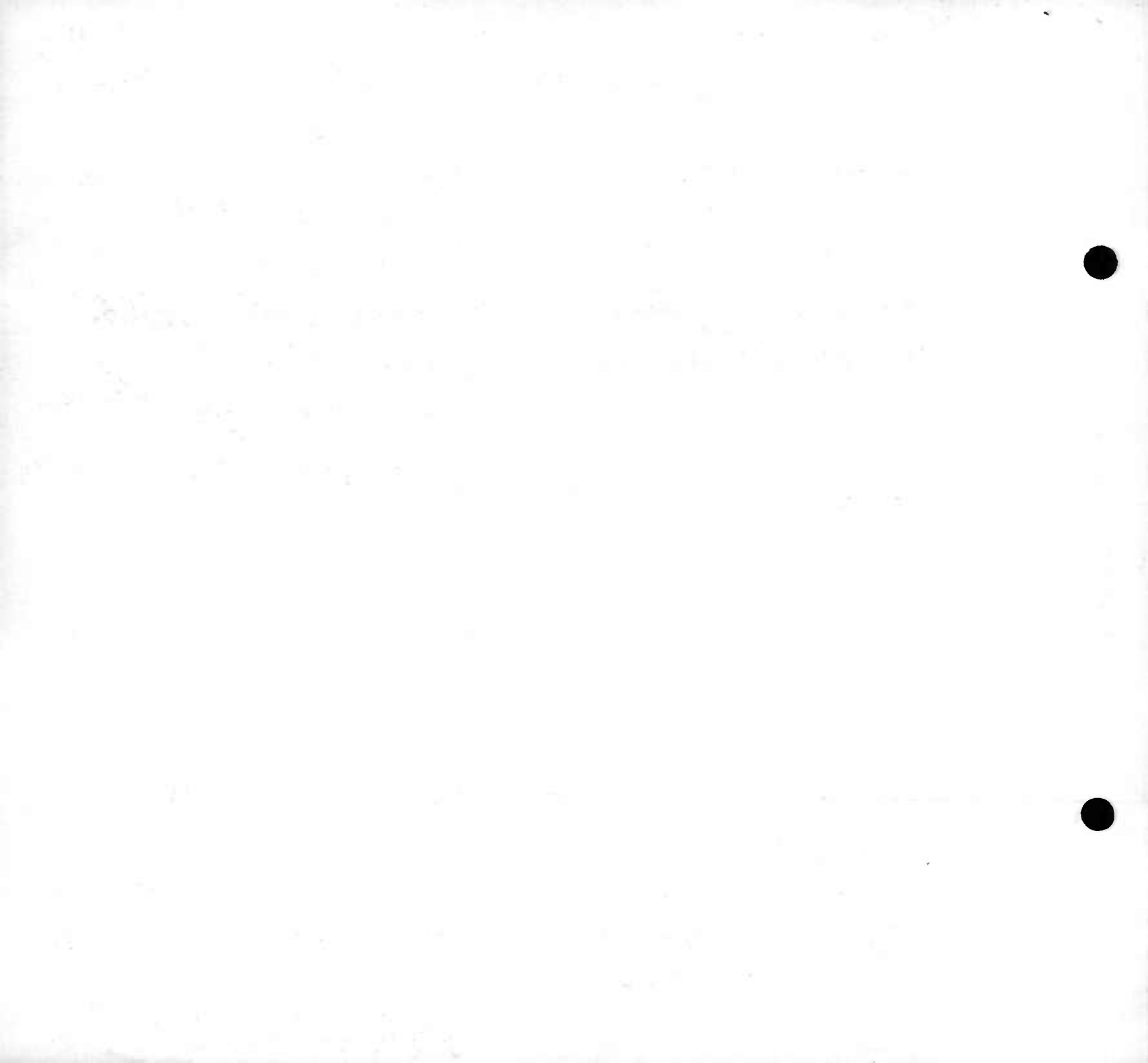
BALTIMORE CITY HEALTH DEPARTMENT				T-622 72 03545		REG. NO. 72 03545	
BIRTH NO.				1. NAME OF DECEASED (Type or Print) <i>Allen Tarses</i>			
2. DATE AND HOUR OF DEATH <i>Sat Apr 8 / 72 12:45 P. M.</i>				3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>md</i> B. COUNTY <i>BALTO</i>				FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <i>38 University Hosp.</i>			
C. CITY OR TOWN <i>Baltimore</i>				D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
E. STREET AND NUMBER <i>6818 Navajo Dr.</i>							
5. SEX <i>Male</i>		6. RACE <i>White</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>3/30/10</i>	
9. AGE (in years lost birthday) <i>62</i>		If Under 1 Yr. Months: Days: Hours: Min.		If Under 24 Hrs. Min.			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Merchant</i>				10B. KIND OF BUSINESS OR INDUSTRY <i>Retail</i>		11. BIRTHPLACE (State or foreign country) <i>Balto, Md</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>				13. FATHER'S NAME <i>Bons Tarses</i>			
14. MOTHER'S MAIDEN NAME <i>Pauline Steffel</i>				15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO.				17. INFORMANT <i>Mrs Charlotte Tarses - Same</i>			
18. <i>410.9 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) IMMEDIATE CAUSE <i>Acute Coronary Occlusion</i> DUE TO, OR AS A CONSEQUENCE OF: (B) <i>Arteriosclerotic Cardiovascular Disease</i> DUE TO, OR AS A CONSEQUENCE OF: (C) _____			
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>5 minutes</i>							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).							
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>No</i>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <i>Jan 1, 1950</i> to <i>April 8, 1972</i> , that (I) (we) last saw the deceased alive on <i>April 8, 1972</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <i>Irving B. Kemick</i>				23B. DATE SIGNED <i>4/9/72</i>			
23C. PHYSICIAN'S NAME (Type) <i>IRVING KEMICK</i>				23D. ADDRESS <i>3101 Szold Dr.</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>4/9/72</i>		24C. NAME OF CEMETERY OR CREMATORY <i>Aqueduct Burial</i>		24D. LOCATION (City, town, or county) (State) <i>Balto Md.</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>APR 12 1972</i>		25B. NAME OF REGISTRAR <i>Robert E. ...</i>		25C. FUNERAL DIRECTOR <i>6000 Pennsylvania Rd.</i>		ADDRESS	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

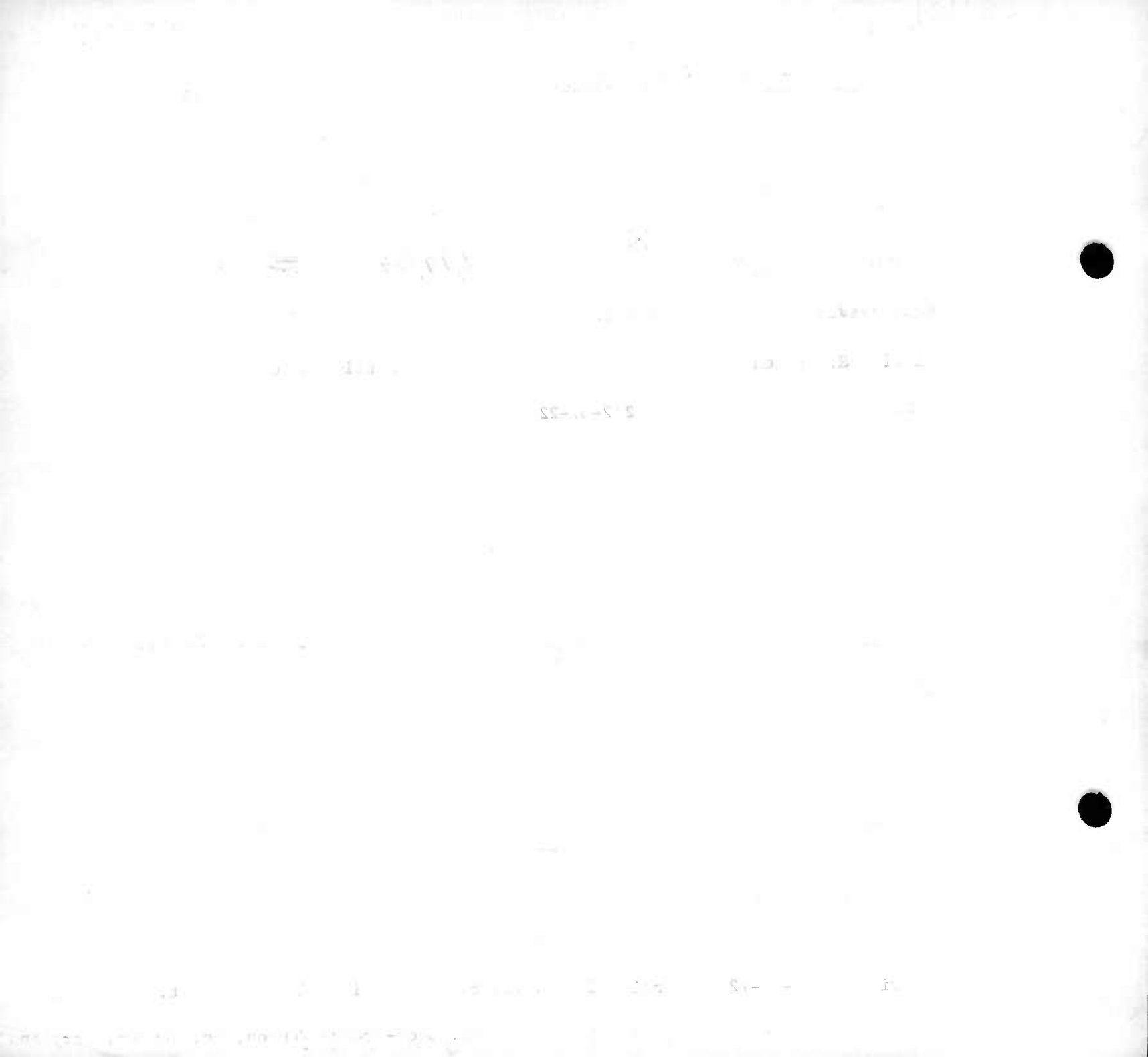
BALTIMORE CITY HEALTH DEPARTMENT				CERTIFICATE OF DEATH		REG. NO. <u>72 03546</u>	
BIRTH NO. 1. NAME OF DECEASED (Type or Print) <u>HELMAN, PAULINE</u>		2. DATE AND HOUR OF DEATH <u>4/8/72</u> <u>8:45 A</u> M.					
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <u>SINAI HOSPITAL</u> (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>42 OF BALTO</u>				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MD</u> B. COUNTY <u>BALTO</u> C. CITY OR TOWN <u>BALTO</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER <u>3812 GLEN AVE.</u>			
5. SEX <u>FEM.</u> 6. RACE <u>CAUCASIAN</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>8/18/08</u> 9. AGE (in years last birthday) <u>63</u>		If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (State or foreign country) <u>Kansas, Leth</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Shelton Kramer</u>				14. MOTHER'S MAIDEN NAME <u>Dora Frank</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Ruth Hersch Heiman</u> ADDRESS <u>Same</u>			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <u>450X1 + 174X</u> (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>PULMONARY EMBOLISM</u> DUE TO, OR AS A CONSEQUENCE OF: (B) _____ DUE TO, OR AS A CONSEQUENCE OF: (C) _____ II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <u>CA OF BREAST</u>			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>4/7</u> 19 <u>72</u> to <u>4/8</u> 19 <u>72</u> that (I) (we) last saw the deceased alive on <u>4/8</u> 19 <u>72</u> and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>[Signature]</u> DEGREE <u>M.D.</u>				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>4/8/72</u>	
23C. PHYSICIAN'S NAME (Type) <u>DAVID GLASER, M.D.</u> DEGREE				23D. ADDRESS <u>SINAI HOSP. OF BALYO.</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>4/9/72</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Annie Emanuel City Chain</u>		24D. LOCATION (City, town, or county) (State) <u>Wash Blvd.</u>	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR <u>6010 Forest Rd.</u> ADDRESS			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT														
W-200 72 03547					CERTIFICATE OF DEATH					REG. NO. 72 03547				
1. NAME OF DECEASED (Type or Print) C. STEWART WAESCHE					2. DATE AND HOUR OF DEATH APRIL 10, 1972 12:40 P.M.									
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD					4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)									
FULL NAME OF HOSPITAL OR INSTITUTION UNIVERSITY OF MARYLAND 38					A. STATE MD.					B. COUNTY CARROL				
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)					C. CITY OR TOWN WESTMINSTER					D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
					E. STREET AND NUMBER RT2 Box 24									
5. SEX Male		6. RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8/19/04		9. AGE (in years last birthday) 67		If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Real Estate					10B. KIND OF BUSINESS OR INDUSTRY Real Estate					11. BIRTHPLACE (State or foreign country) MARYLAND				
12. CITIZEN OF WHAT COUNTRY? U.S.A.					13. FATHER'S NAME William H. Waesche					14. MOTHER'S MAIDEN NAME Nettie Leach				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No					16. SOCIAL SECURITY NO. 212-07-2254					17. INFORMANT HOSP. CHART				
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) 570X 14205.0					CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: HEPATIC NECROSIS					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 DAYS				
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					(B) DUE TO, OR AS A CONSEQUENCE OF:									
(C) DUE TO, OR AS A CONSEQUENCE OF:														
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). ACUTE MYELO MONOCYTIC LEUKEMIA 4 MONTHS BILATERAL INTERSTITIAL PNEUMONITIS 2 MONTHS														
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?							
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)									
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?									
22. I certify that (I) (this hospital) attended the deceased from 3/29 19 72 to 4/10 19 72 that (I) was last saw the deceased alive on 4/10 19 72 and that in (my) own opinion death occurred on the date and hour and from the causes stated above. (I) was (did) not view the body after death.														
23A. SIGNATURE MEYER R. HEYMAN M.D.					23B. DATE SIGNED 4/10/72									
23C. PHYSICIAN'S NAME (Type) MEYER R. HEYMAN M.D.					23D. ADDRESS UNIV. OF MARYLAND HOSP.									
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4-14-72		24C. NAME OF CEMETERY Druid Ridge Cemetery			24D. LOCATION (City, town, or county) (State) Pikesville Balt. Md.							
25A. DATE AND PLACE OF BIRTH APR 12 1904					25B. NAME OF REGISTRAR Wm. Cook-Brooks					25C. FUNERAL DIRECTOR Wm. Cook-Brooks Towson, Inc. Towson, Maryland				



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 03548	
B-150 72 03548 CERTIFICATE OF DEATH		72 03548 72 03548			
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
MYER RUBIN		APRIL 10, 1972		4:58 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION 5825 GIST AVENUE 00		A. STATE		B. COUNTY	
		MARYLAND			
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 5825 GIST AVENUE 00		C. CITY OR TOWN		D. INSIDE CITY LIMITS?	
		BALTIMORE		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER			
		5825 GIST AVENUE #21215			
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months; Days
MALE	WHITE	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	MARCH 1884	88	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
DEALER N		RAW FURS		RUSSIA	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
MENASHA RUBIN		UNKNOWN		USA	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
NO				MR. JOSEPH RUBIN, 3716 GLEN AVENUE #21215	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH			
(This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury at complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Hypostatic Pneumonia</i>			
ANTECEDENT CAUSES		(B) DUE TO, OR AS A CONSEQUENCE OF: <i>Cerebral Embolism</i>			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) _____			
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from <i>January 11</i> to <i>April 10</i> 19 <i>72</i> , that (I) (we) last saw the deceased alive on <i>4/10/72</i> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
<i>Samuel Rubin</i> DEGREE				<i>4/10/72</i>	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
SAMUEL RUBIN				3510 SEQUOIA AVENUE	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
BURIAL		4-11-72		BOBROISKER BENEFICIAL CIRCLE, ROSEDALE, MARYLAND	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
APR 12 1972		RUBIN, J. M.		SQL LEVINSON, & BROS., 6010 REISTERSTOWN ROAD	

RECEIVED
JAN 10 1964
U.S. AIR FORCE

NAME: WHITE
RANK: MAJOR
BRANCH: AIR FORCE
SERIAL: 100000000
UNIT: 100000000

MR. J. WHITE, JR., 100000000

John White, Jr.

John White, Jr.

John White, Jr.

John White, Jr.

100000000

100000000

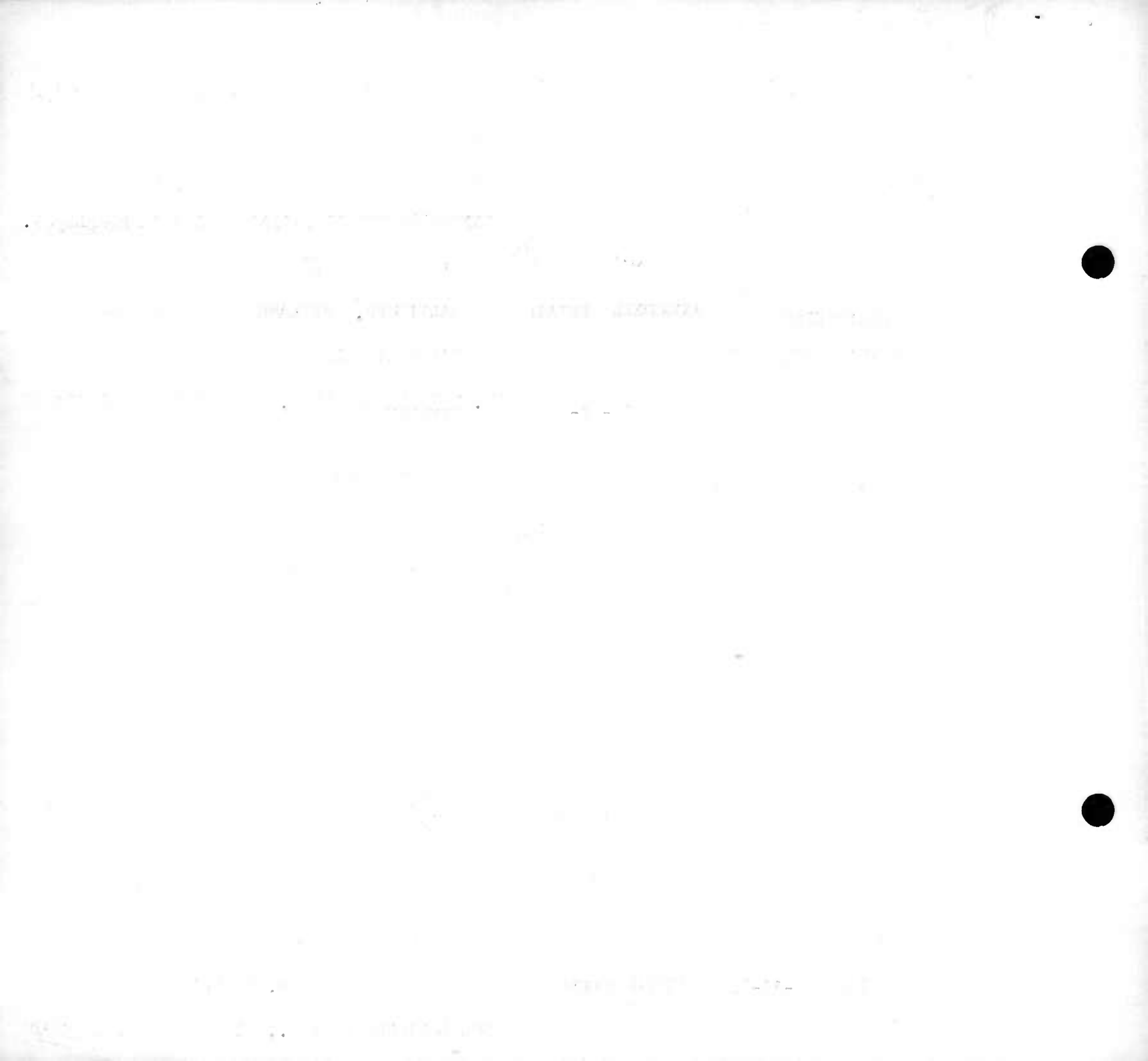
100000000

100000000

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

<p>R-252 72 03549</p> <p style="text-align: right;">BALTIMORE CITY HEALTH DEPARTMENT</p> <p style="text-align: center;">CERTIFICATE OF DEATH</p> <p style="text-align: right;">REG. NO. <u>72 03549</u></p>	
<p>BIRTH NO. <u>72 03549</u></p>	
<p>1. NAME OF DECEASED (Type or Print) <u>ROSENKOFF, HYMAN</u></p>	
<p>2. DATE AND HOUR OF DEATH <u>4-10-72</u> <u>4:05 A.M.</u></p>	
<p>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</p> <p>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>Lutheran Hospital</u></p>	
<p>4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)</p> <p>A. STATE <u>md.</u> B. COUNTY <u>302</u></p>	
<p>C. CITY OR TOWN <u>Balto.</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></p>	
<p>E. STREET AND NUMBER <u>102 ALBEMARLE ST.</u></p>	
<p>5. SEX <u>male</u></p>	<p>6. RACE <u>white</u></p>
<p>7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/></p>	<p>8. DATE OF BIRTH <u>7-28-96</u></p>
<p>9. AGE (In years last birthday) <u>75</u></p>	<p>If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.</p>
<p>10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>ELECTRICIAN</u></p>	<p>10B. KIND OF BUSINESS OR INDUSTRY <u>RETAIL</u></p>
<p>11. BIRTHPLACE (State or foreign country) <u>BALTIMORE, MARYLAND</u></p>	<p>12. CITIZEN OF WHAT COUNTRY? <u>USA</u></p>
<p>13. FATHER'S NAME <u>NATHAN ROSENKOFF</u></p>	
<p>14. MOTHER'S MAIDEN NAME <u>SARAH NIMETZ</u></p>	
<p>15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)</p>	<p>16. SOCIAL SECURITY NO. <u>212-01-9041</u></p>
<p>17. INFORMANT <u>MR. NORMAN ROSENKOFF</u> ADDRESS <u>5316 GIST AVENUE #21215</u></p>	
<p>18. <u>250.91</u> CAUSE OF DEATH</p> <p>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</p> <p>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)</p> <p>ANTECEDENT CAUSES</p> <p>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p> <p>(A) IMMEDIATE CAUSE <u>CARDIO-RESPIRATORY ARREST</u></p> <p>(B) <u>DIABETES MELLITUS</u></p> <p>(C) <u>ISCHAEMIC HEART DISEASE</u></p> <p>II</p> <p>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).</p>	
<p>19A. DATE OF OPERATION <u>0</u></p>	<p>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</p>
<p>20A. AUTOPSY? (Yes or No) <u>No</u></p>	<p>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</p>
<p>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)</p>	<p>21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)</p>
<p>21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)</p>	<p>21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)</p>
<p>21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/></p>	<p>21F. HOW DID INJURY OCCUR?</p>
<p>22. I certify that (I) (this hospital) attended the deceased from <u>3-29-1972</u> to <u>4-10-1972</u> that (I) (we) last saw the deceased alive on <u>4-9-1972</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</p>	
<p>23A. SIGNATURE <u>Samuel J. Edwin</u> MD</p>	
<p>23B. DATE SIGNED <u>4.10.72</u></p>	
<p>23C. PHYSICIAN'S NAME (Type) <u>SAMUEL J. EDWIN</u> MD</p>	
<p>23D. ADDRESS <u>Lutheran Hospital, 730 Ashburton St., Balto., Md., 21216.</u></p>	
<p>24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u></p>	<p>24B. DATE <u>4-11-72</u></p>
<p>24C. NAME OF CEMETERY or CREMATORY <u>MIKRO KODESH</u></p>	<p>24D. LOCATION (City, town, or county) (State) <u>BALTIMORE, MARYLAND</u></p>
<p>25A. DATE REC'D BY HEALTH DEPT. <u>APR 12 1972</u></p>	<p>25B. NAME OF REGISTRAR <u>Robert S. Taylor, M.D.</u></p>
<p>25C. FUNERAL DIRECTOR <u>SOL LEVINSON & BROS.</u> ADDRESS <u>6010 REISTERSTOWN ROAD</u></p>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT 72 03550						72 03550	
B-452						REG. NO.	
1. NAME OF DECEASED (Type or Print) AARON BLANKMAN						2. DATE AND HOUR OF DEATH 4/9/72 4:30 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD						4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION SINAI HOSPITAL 42						A. STATE MARYLAND B. COUNTY 1510	
IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION						C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
						E. STREET AND NUMBER 3901 DOLFIELD AVENUE #21215	
5. SEX MALE	6. RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH APRIL 7, 1892	9. AGE (In years last birthday) 80	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MERCHANT		10B. KIND OF BUSINESS OR INDUSTRY RETAIL		11. BIRTHPLACE (State or foreign country) RUSSIA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME MORTON BLANKMAN				14. MOTHER'S MAIDEN NAME ANNA SHULMAN			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO				16. SOCIAL SECURITY NO. 219-32-1237		17. INFORMANT ADDRESS MRS. EVA BLANKMAN, 3901 DOLFIELD AVE. #21215	
18. CAUSE OF DEATH						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) 410.0 I						Coronary Occlusion 1 hour?	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.						(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) Hypertensive arteriosclerotic cardiovascular changes 5 years (C)	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).							
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) 1 Month 1 Day (Year) 1 Hour		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from Jan 10 1968 to April 9 1972 that (I) (we) last saw the deceased alive on April 6 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Leonard Wallenstein DEGREE						23B. DATE SIGNED 4/9/72	
23C. PHYSICIAN'S NAME (Type) LEONARD WALLENSTEIN DEGREE						23D. ADDRESS 848 W 36th St Baltimore 21211 MD	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 4-11-72		24C. NAME of CEMETERY or CREMATORY BALTIMORE HEBREW		24D. LOCATION (City, town, or county) (State) REISTERSTOWN, MARYLAND	
25A. DATE REC'D BY HEALTH DEPT. APR 12 1972		25B. NAME OF REGISTRAR Robert E. Wallenstein		25C. FUNERAL DIRECTOR ADDRESS SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD			

RECEIVED

WHITE T. 1900

1900

WHITE T. 1900

RECEIVED

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

7-623		72 03551		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 03551	
BIRTH NO.				1			
1. NAME OF DECEASED (Type or Print) Robert <i>Charles A. Forrest</i>				2. DATE AND HOUR OF DEATH <i>4-7-72 9:30 A.M.</i>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <i>49 North Charles Gen Hosp</i> <i>Buth Md</i>				A. STATE <i>Maryland</i> B. COUNTY <i>1503</i>			
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				C. CITY OR TOWN <i>Baltimore</i>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <i>M</i>				6. RACE <i>Negro</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>DISABLED</i>				10B. KIND OF BUSINESS OR INDUSTRY <i>—</i>		8. DATE OF BIRTH <i>9-16-88</i>	
11. BIRTHPLACE (State or foreign country) <i>Maryland</i>				9. AGE (In years last birthday) <i>83</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	
13. FATHER'S NAME <i>JOHN A. Forrest</i>				14. MOTHER'S MAIDEN NAME <i>Winifred Jones</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <i>213-22-1570</i>		17. INFORMANT <i>JAMES FORREST, LEONARDTOWN, MD</i>	
18. <i>531.0 + 157.9</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ACUTE GASTROINTESTINAL HEMORRHOGE <i>acute gastritis</i> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <i>20 to anacanth gastritis</i> <i>Carcinoma of pancreas</i>				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) <i>Carcinoma of pancreas</i>			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
19A. DATE OF OPERATION <i>3-30-72</i>				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Obstructive jaundice</i>		20A. AUTOPSY? (Yes or No) <i>yes</i>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>3-23-72</i> 19 to <i>4-7-72</i> 1972 that (I) (we) last saw the deceased alive on <i>4-7-72</i> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <i>Narciso A. de Borja</i>				DEGREE		23B. DATE SIGNED <i>4-7-72</i>	
23C. PHYSICIAN'S NAME (Type) <i>Narciso A. de Borja</i>				23D. ADDRESS <i>North Charles Gen. Hosp.</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>BURIAL</i>				24B. DATE <i>4/11/72</i>		24C. NAME OF CEMETERY OR CREMATORY <i>ST. PETER CLAYER CEM.</i>	
24D. LOCATION (City, town, or county) (State) <i>RIDGE, MARYLAND</i>				25A. DATE REC'D BY HEALTH DEPT. <i>APR 12 1972</i>			
25B. NAME OF REGISTRAR <i>Robert E. Farber, M.D.</i>				25C. FUNERAL DIRECTOR <i>John M. Welch, Leonardtown, Md</i>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>72 03552</u>	
S-462 72 03552		CERTIFICATE OF DEATH			
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		Mary L. Sellers		4/11/72 1:30 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution residence before admission) A. STATE B. COUNTY		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			C. CITY OR TOWN D. INSIDE CITY LIMITS?		
Md. General Hospital			Baltimore, Md. YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
			E. STREET AND NUMBER		
			1803 Buxton Avenue		
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. UNDER 1 Yr. Months Days
Female	Negro		5/21/01	70	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Domestic		Pub. Family		Maryland	
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
Frank Thomas			Mannie Wood		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
No		57948-8643		Mrs. Mary V. Dean Wash. D.C. 3913 21st St. N.E.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH Carcinoma of Stomach (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		
			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 months		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
2				yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR (If in Baltimore City, give exact location)	
				yes	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from April 7 1972 to April 11 1972 that (I) (we) last saw the deceased alive on April 11 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE			23B. DATE SIGNED		
Willard P. Amoss M.D.			4/11/72		
23C. PHYSICIAN'S NAME (Type)			23D. ADDRESS		
Willard P. Amoss M.D.			Md. General Hosp., Balto. Md.		
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		4-15-72		Mt. Olivet Cem.	
				Washington D.C.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
APR 12 1972		John E. Sellers, D.O.		Nutter Funeral Home 3035 W. North Ave.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Baltimore City Health Department				CERTIFICATE OF DEATH		REG. NO. 72 03553	
1. NAME OF DECEASED (Type or Print) Brian K.		2. DATE AND HOUR OF DEATH 4-6-72		3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY 2505	
5. SEX MALE		6. RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 4-5-72	
9. AGE (In years last birthday) ---		10. If Under 1 Yr. Months: 9 Days: ---		11. If Under 24 Hrs. Hours: --- Min. ---		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) n/a				10B. KIND OF BUSINESS OR INDUSTRY n/a		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME DWAYNE WILLIAMS				14. MOTHER'S MAIDEN NAME NAOMI LAUGHERY			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) n/a		16. SOCIAL SECURITY NO. n/a		17. INFORMANT Mary Laughery (Grandmother)		ADDRESS 21225	
18. 227, 11		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		Hypovolemic cardiac arrest		---	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) bleeding diaphysis DUE TO, OR AS A CONSEQUENCE OF:		23 hrs			
(C) giant hemangioma of liver - ruptured				24 hrs			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). prematurity							
19A. DATE OF OPERATION 4/5		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED hemangioma of liver		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 6 AM 4/5 19 72 to 2:45 AM 4/6 19 72 that (I) (we) last saw the deceased alive on 4/6 19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Jean F. Hobbs				23B. DATE SIGNED 4/6/72			
23C. PHYSICIAN'S NAME (Type) JEAN F. HOBBS				23D. ADDRESS THE JOHNS HOPKINS HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4/12/72		24C. NAME OF CEMETERY or CREMATORY Glen Haven Cemetery		24D. LOCATION (City, town, or county) (State) Anne Arundel Co.; Balto., Md.	
25A. DATE REC'D BY HEALTH DEPT. APR 13 1972		25B. NAME OF REGISTRAR Patapsco		25C. FUNERAL DIRECTOR McCully F. H.		ADDRESS 237 Patapsco Ave.; Balto. 21225	

T. 100

Y. 100

100-100

100-100

100-100

100-100

100-100

100-100

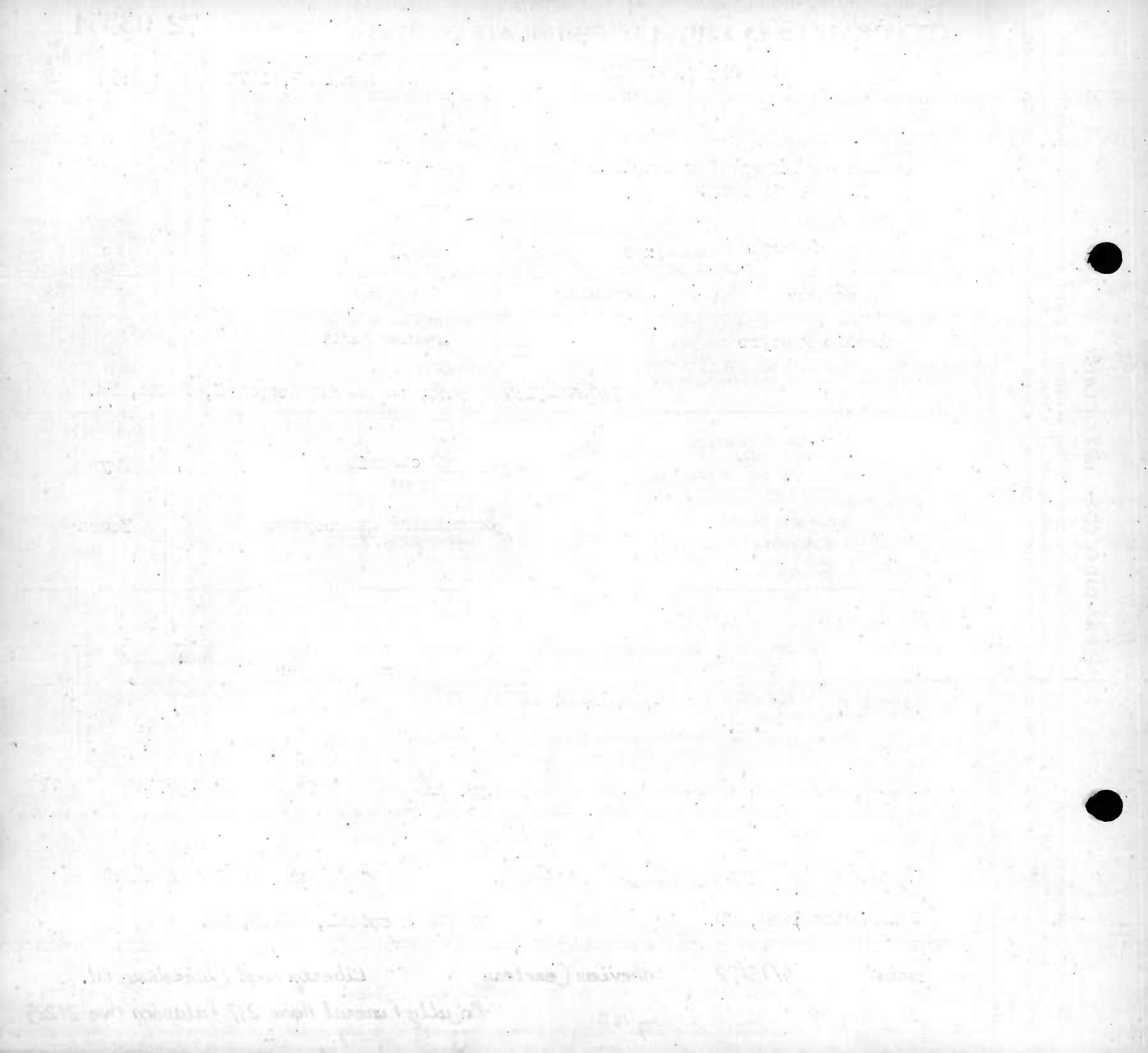
100-100

100-100

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

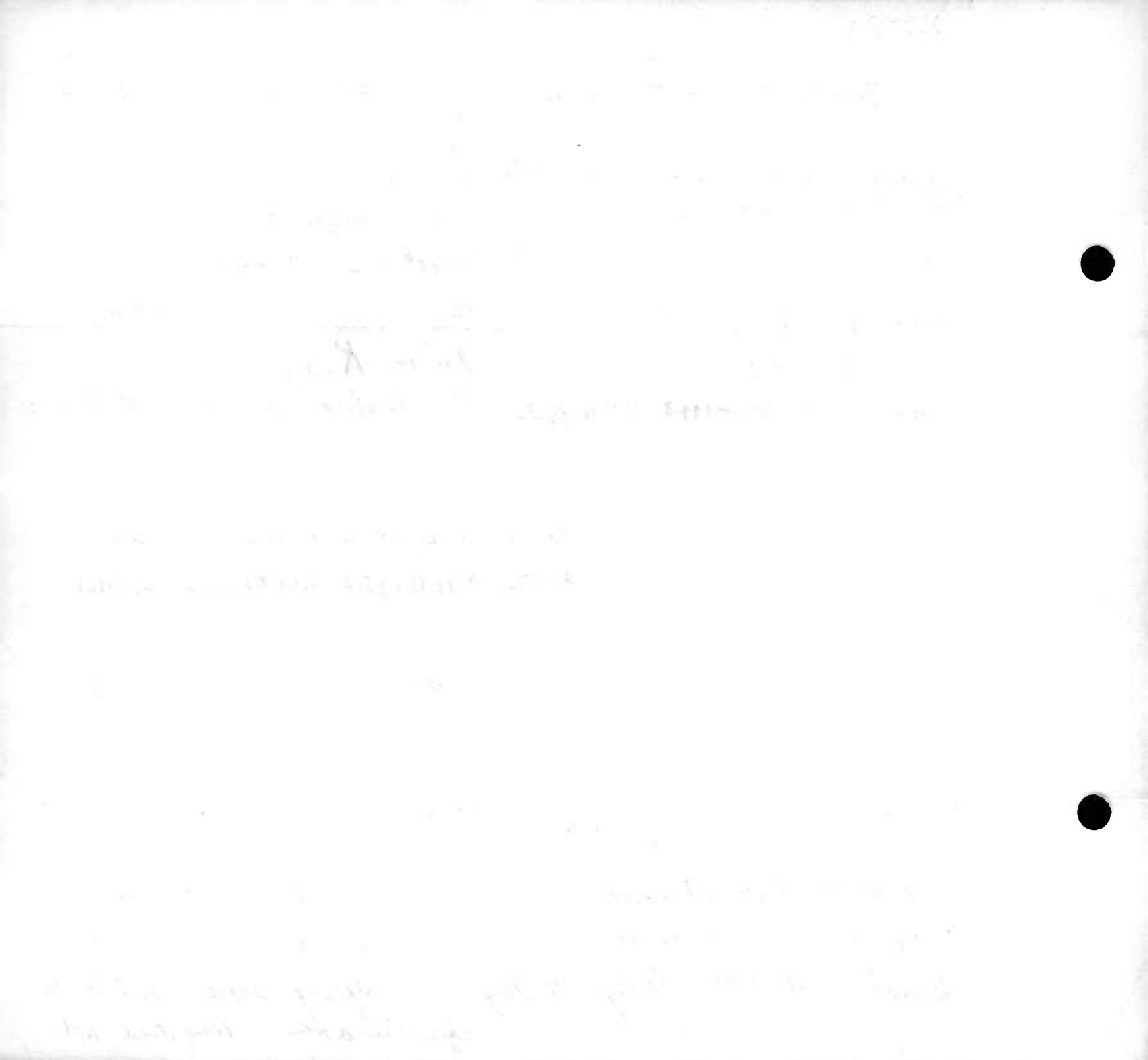
BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 03554	
P-560 72 03554		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) CLAUDIO O. PINEYRO		2. DATE AND HOUR OF DEATH April 12, 1972 4:30 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) US Public Health Service Hospital 2X 3100 Wyman Pkwy.		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Md. B. COUNTY AA 5200 C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 5110 Kramme Ave.	
5. SEX M	6. RACE Caucasian	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/18/13
9. AGE (In years lost birthday) 58		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) AB seaman	
10B. KIND OF BUSINESS OR INDUSTRY Seafarer		11. BIRTHPLACE (State or foreign country) Uruguay	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Claudio Pineyro	
14. MOTHER'S MAIDEN NAME Ramona Porta		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No	
16. SOCIAL SECURITY NO. 140-22-3157		17. INFORMANT Records- US PHS Hospital, Balto, Md.	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 197X I Pneumonia (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Cerebellar astrocytoma (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____ ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Days Years	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? yes	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (X) (this hospital) attended the deceased from Apr. 11 19 72 to Apr. 12 19 72 , that (X) (we) lost saw the deceased alive on Apr. 12 19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (did not) view the body after death.			
23A. SIGNATURE John C. Sutherland, MD		23B. DATE SIGNED 4/12/72	
23C. PHYSICIAN'S NAME (Type) John Sutherland, MD.		23D. ADDRESS US PHS Hospital, Balto, Md.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 4/15/72	24C. NAME OF CEMETERY OR CREMATORY Lakeview Cemetery	24D. LOCATION (City, town, or county) (State) Liberty Road Eldersburg Md.
25A. DATE REC'D BY HEALTH DEPT. APR 13 1972	25B. NAME OF REGISTRAR Robert E. Taylor, Jr.	25C. FUNERAL DIRECTOR McCully Funeral Home 237 Patapsco Ave 21225	



FUNERAL DIRECTOR: IMPORTANT

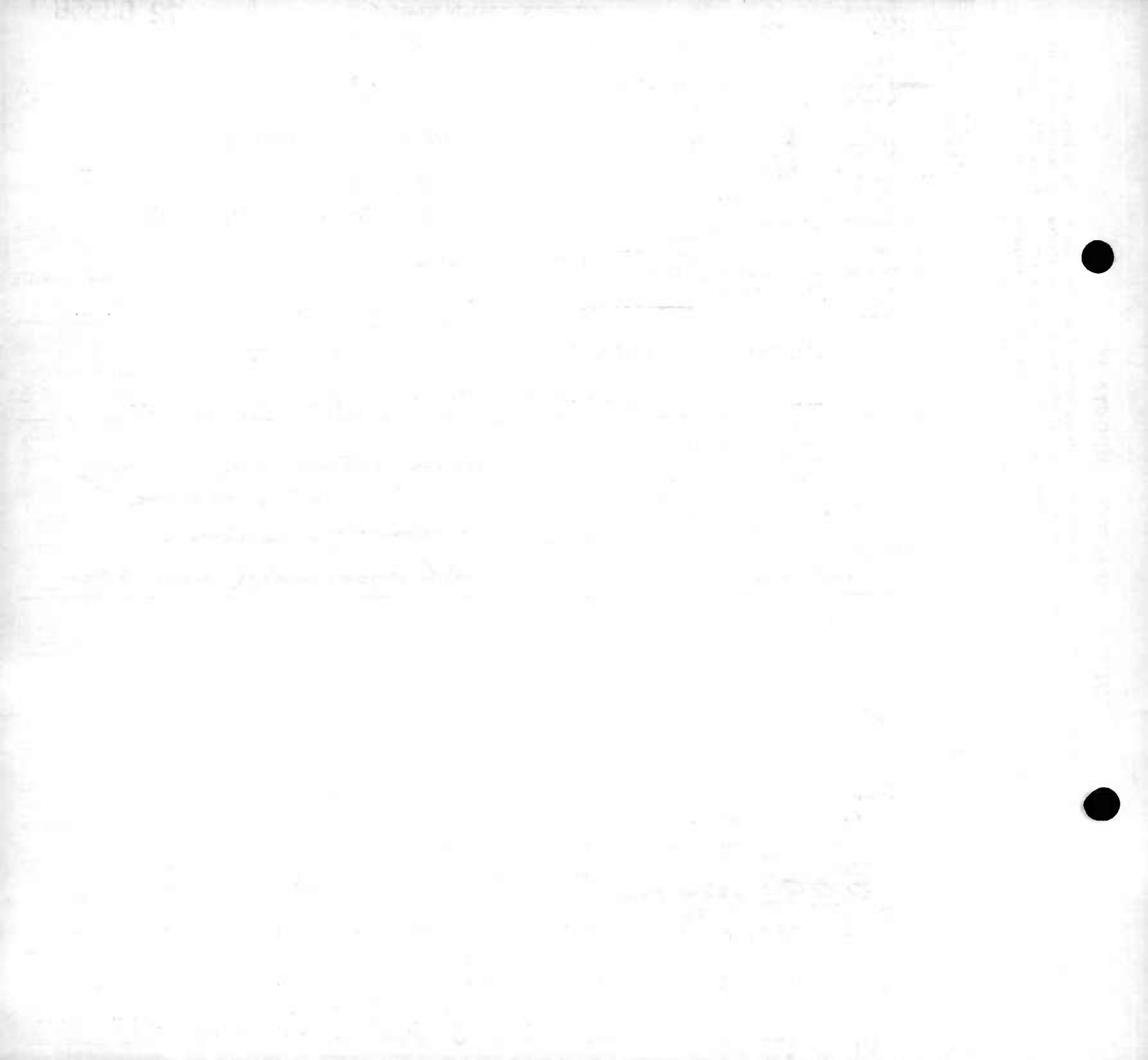
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		REG. NO. 72 03555	
X-520		72 03555			
BIRTH NO.		72 03555			
1. NAME OF DECEASED (Type or Print)		YOUNG, Edward Franklin		2. DATE AND HOUR OF DEATH 4-9-72 11 A M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE Pa. B. COUNTY V 35			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) UNITED STATES PUBLIC HEALTH SERV HOSPITAL, Baltimore		C. CITY OR TOWN HANOVER		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX M		6. RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unemp.		10B. KIND OF BUSINESS OR INDUSTRY —		8. DATE OF BIRTH MAY 17 1916 55-56	
13. FATHER'S NAME Tilman Young		14. MOTHER'S MAIDEN NAME Annrie Kuyf		9. AGE (in years last birthday) 55-56	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES 3 1942-1943		16. SOCIAL SECURITY NO. 60 10 35 33		11. BIRTHPLACE (State or foreign country) Pa.	
17. INFORMANT Maria de Moraes-Rubben - Baltimore		12. CITIZEN OF WHAT COUNTRY? USA			
18. 20570 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: SEPSIS Rt. Lobular pneumonia Acute Myelocytic Leukemia		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH days days 2 mos	
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Feb. 13 19 72 to Apr. 9 19 72 that (I) (we) last saw the deceased alive on Apr. 9 19 72 and that (in/ry) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Maria de Moraes-Rubben		23B. DATE SIGNED 4-9-72		23C. PHYSICIAN'S NAME (Type) MARIA DE MORAES - RUEHSEN	
23D. ADDRESS 1747 STOKESLEY Rd. Balto 21222		23E. DEGREE DEGREE		23F. DEGREE DEGREE	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4-13-72		24C. NAME OF CEMETERY OR CREMATORY Larchmont Cemetery	
24D. LOCATION Spring Grove, York Co Pa.		24E. LOCATION (City, town, or county)		24F. LOCATION (State)	
25A. DATE REC'D BY HEALTH DEPT. APR 13 1972		25B. NAME OF REGISTRAR Robert J. Faber		25C. FUNERAL DIRECTOR Edwin Farnham Home	
25D. ADDRESS Nompstead Md.		25E. ADDRESS (City, town, or county)		25F. ADDRESS (State)	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

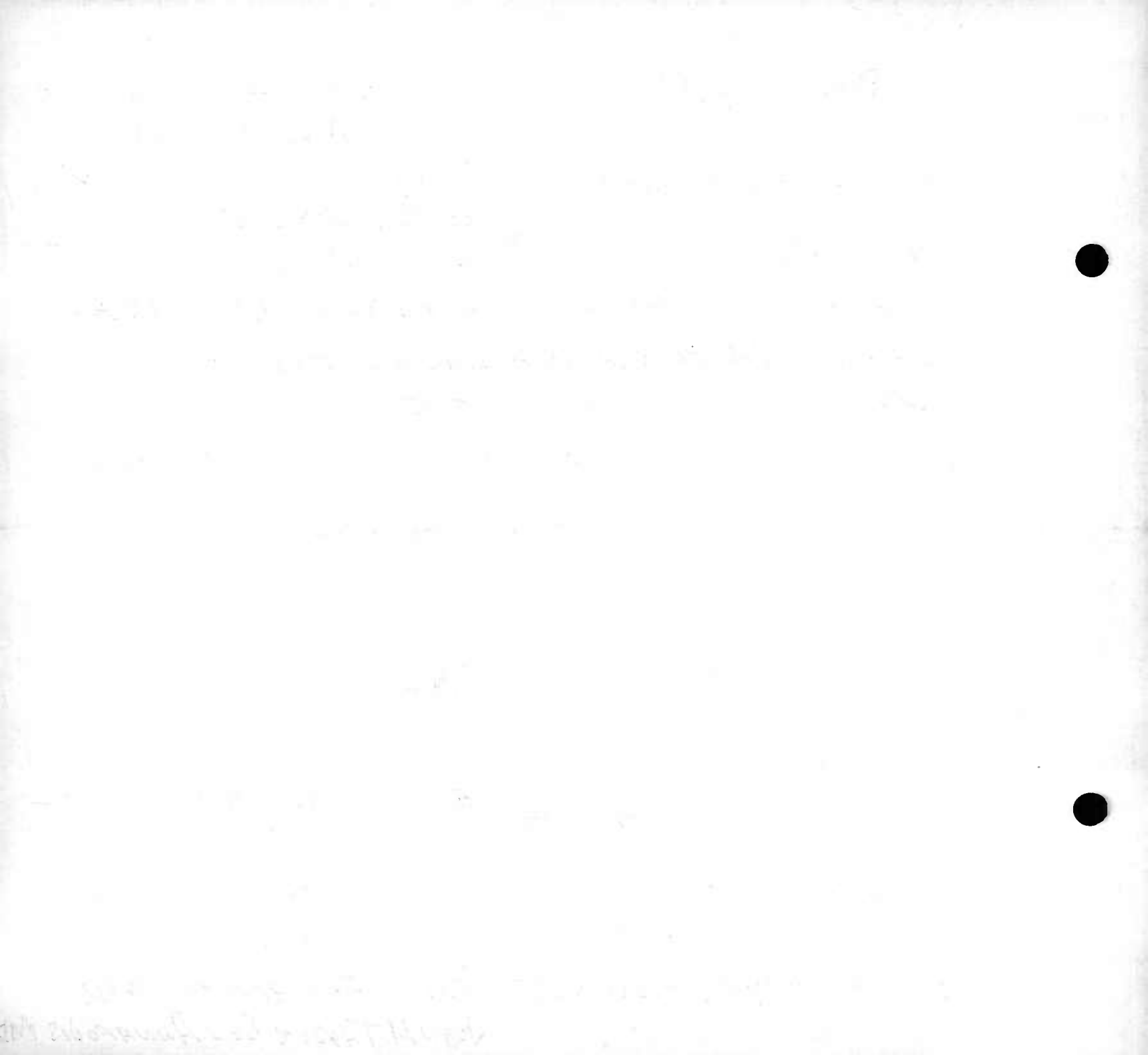
VS 150-REV. 1/1/68



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

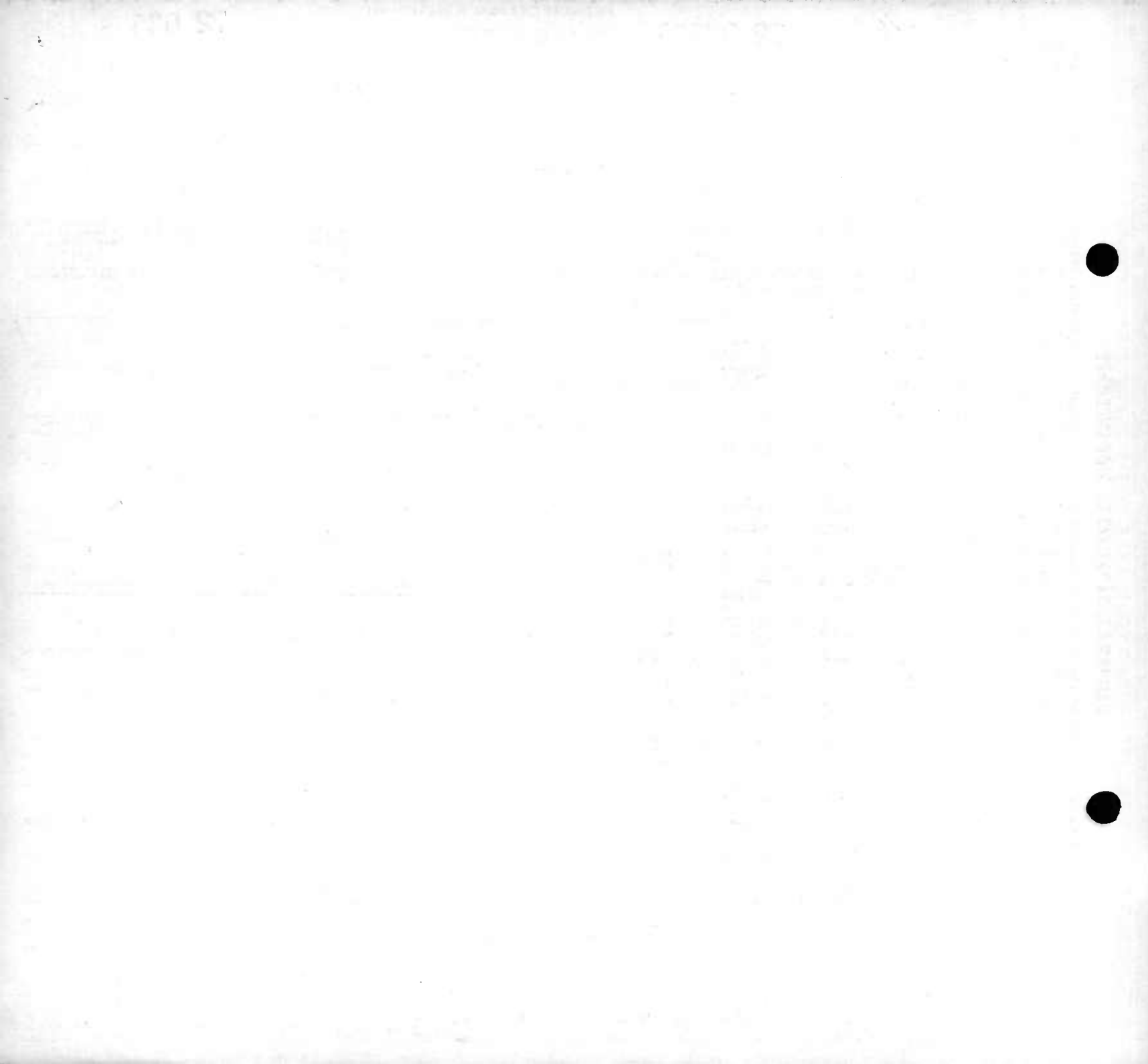
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>72 03557</u>
<p>P-565 72 03557</p> <p>BIRTH NO. <u>Annapolis, Md.</u></p> <p>1. NAME OF DECEASED (Type or Print) <u>Pomraning, Martha W.</u></p> <p>2. DATE AND HOUR OF DEATH <u>4-5-72</u> <u>8:20 P.M.</u></p>		<p>CERTIFICATE OF DEATH</p>		
<p>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</p> <p>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>Johns Hopkins Hospital</u></p>		<p>4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>Anne Arundel</u></p> <p>C. CITY OR TOWN <u>Annapolis</u> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></p> <p>E. STREET AND NUMBER <u>ROUTE 1 Box 375</u></p>		
<p>5. SEX <u>F.</u></p>	<p>6. RACE <u>W.</u></p>	<p>7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/></p>	<p>8. DATE OF BIRTH <u>12-1-1968</u> 9. AGE (In years) <u>3</u> 10. UNDER 1 Yr. <u>Months</u> <u>Days</u> 11. UNDER 24 Hrs. <u>Hours</u> <u>Min.</u></p>	
<p>10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE</u></p>		<p>10B. KIND OF BUSINESS OR INDUSTRY <u>NONE</u></p>		<p>11. BIRTHPLACE (State or foreign country) <u>ANNAPOLIS MD.</u></p>
<p>12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u></p>		<p>13. FATHER'S NAME <u>CHARLES M. POMRANING</u></p>		
<p>14. MOTHER'S MAIDEN NAME <u>LUCILE FITCH</u></p>		<p>15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) <u>No</u></p>		
<p>16. SOCIAL SECURITY NO. <u># 13</u></p>		<p>17. INFORMANT ADDRESS</p>		
<p>18. CAUSE OF DEATH</p>				
<p>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)</p> <p><u>Cardiorespiratory Arrest</u></p> <p>ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p> <p><u>Meningococcemia</u></p>				
<p>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>32 hrs.</u></p>				
<p>II</p>				
<p>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).</p>				
<p>19A. DATE OF OPERATION <u>2</u></p>		<p>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</p>		<p>20A. AUTOPSY? (Yes or No) <u>Yes</u></p>
<p>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</p>		<p>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)</p>		
<p>21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)</p>		<p>21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)</p>		
<p>21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)</p>		<p>21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/></p>		<p>21F. HOW DID INJURY OCCUR?</p>
<p>22. I certify that (I) (this hospital) attended the deceased from <u>4-5-72</u> 19 <u>72</u> to <u>4-5</u> 19 <u>72</u></p> <p>that (I) (we) last saw the deceased alive on <u>4-5-72</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</p>				
<p>23A. SIGNATURE <u>Raymond C. Baker, M.D.</u></p>				<p>23B. DATE SIGNED <u>4-5-72</u></p>
<p>23C. PHYSICIAN'S NAME (Type) <u>Raymond C. Baker, M.D.</u></p>				<p>23D. ADDRESS <u>601 N. Broadway</u></p>
<p>24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u></p>		<p>24B. DATE <u>4/7/72</u></p>		<p>24C. NAME OF CEMETERY OR CREMATORY <u>HILLCREST CEM.</u></p>
<p>24D. LOCATION (City, town, or county) (State) <u>ANNAPOLIS MD.</u></p>		<p>25A. DATE REC'D BY HEALTH DEPT. <u>APR 13 1972</u></p>		
<p>25B. NAME OF REGISTRAR <u>Robert E. Taylor, M.D.</u></p>		<p>25C. FUNERAL DIRECTOR ADDRESS <u>JOHN M. TAYLOR SON ANNAPOLIS MD</u></p>		



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <u>S-162</u>		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. <u>72 03558</u>	
1. NAME OF DECEASED (Type or Print) <u>JAMES M. SPRIGGS</u>			2. DATE AND HOUR OF DEATH <u>4/12/72</u> <u>1 15</u> A.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>001308 N. Spring Street</u>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MARY</u> B. COUNTY <u>BALTIMORE CITY</u> <u>909</u>		
			C. CITY OR TOWN <u>BALTIMORE</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER <u>1308 N. SPRING ST</u>		
5. SEX <u>M</u>	6. RACE <u>N</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9/22/1910</u>	9. AGE (In years last birthday) <u>61</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Beth. Steel</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>STEELWORKER</u>		11. BIRTHPLACE (State or foreign country) <u>BALTIMORE, MD</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>William H. SPRIGGS</u>			
14. MOTHER'S MAIDEN NAME <u>SARA ELLEN TRAVERS</u>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>			
16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <u>Lois Brown (sister)</u>			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <u>155701</u>			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Hepato-renal syndrome</u> <u>2 months</u>		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(B) DUE TO, OR AS A CONSEQUENCE OF: <u>Metastatic HEPATOMA</u> <u>13 months</u>		
			(C) <u>SEVERE HEPATIC CIRRHOSIS</u> <u>2 years</u>		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			<u>congestive heart failure</u> <u>1 year</u>		
19A. DATE OF OPERATION <u>3/19/71</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>hepatic mass</u>		20A. AUTOPSY? (Yes or No) <u>No</u>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>4/1</u> 19 <u>71</u> to <u>4/12</u> 19 <u>72</u> that (I) (we) last saw the deceased alive on <u>4/8</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (We) (did not) view the body after death.					
23A. SIGNATURE <u>Clouse M. Harman MD</u>				23B. DATE SIGNED <u>4/12/72</u>	
23C. PHYSICIAN'S NAME (Type) <u>Eloise M. Harman MD</u>				23D. ADDRESS <u>Johns Hopkins Hospital Baltimore Md 21205</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>4-15-72</u>		24C. NAME of CEMETERY or CREMATORY <u>Arboretus Mem Park Arboretus, Md.</u>	
24D. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>		25A. DATE REC'D BY HEALTH DEPT. <u>APR 13 1972</u>			
25B. NAME OF REGISTRAR <u>Robert E. Johnson</u>		25C. FUNERAL DIRECTOR <u>Wilton E. Elckson</u>		25D. ADDRESS <u>1297 Carroll</u>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT														
M-624 72 03559					CERTIFICATE OF DEATH					REG. NO. 72 03559				
1. NAME OF DECEASED (Type or Print) MARSHALL, WILLIAM E. JR					2. DATE AND HOUR OF DEATH 4-11-72 10 00 A.M.									
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD Provident Hospital					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD B. COUNTY 1402									
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Provident Hospital					C. CITY OR TOWN Balto.					D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
					E. STREET AND NUMBER 1522 Shields Place									
5. SEX Male		6. RACE Colored		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 30, 1897		9. AGE (In years lost birthday) 74		10. Under 1 Yr. Months Days		11. Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer					10B. KIND OF BUSINESS OR INDUSTRY Retired					11. BIRTHPLACE (State or foreign country) Balto. Md				
12. CITIZEN OF WHAT COUNTRY?					13. FATHER'S NAME William E. Marshall					14. MOTHER'S MAIDEN NAME Henriette				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No					16. SOCIAL SECURITY NO. 212-10-8252A					17. INFORMANT ANNIE ROBINSON 1518 Shields Pl.				
18. 43371 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Cerebral Embolism					(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: 18 days									
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					(B) DUE TO, OR AS A CONSEQUENCE OF:									
(C) _____														
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). ASCUD														
19A. DATE OF OPERATION 2					19B. CONDITION FOR WHICH OPERATION WAS PERFORMED					20A. AUTOPSY? (Yes or No) YES				
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? NO														
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>					21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)					21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)					21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					21F. HOW DID INJURY OCCUR?				
22. I certify that (I) (this hospital) attended the deceased from 3-26 19 72 to 4-11 19 72 that (I) (we) last saw the deceased alive on 4-11 19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.														
23A. SIGNATURE M. J. Shaf					23B. DATE SIGNED 4-11-72									
23C. PHYSICIAN'S NAME (Type) M. J.					23D. ADDRESS DEGREE									
24A. BURIAL CREMATION, REMOVAL (Specify) Burial					24B. DATE 4/15/72					24C. NAME OF CEMETERY OR CREMATORY Mt. Auburn Cem.				
24D. LOCATION Balto. Md.					25A. DATE REC'D BY HEALTH DEPT. APR 13 1972					25B. NAME OF REGISTRAR DECEASED				
25C. FUNERAL DIRECTOR Williams Funeral Home					25D. ADDRESS 319 N. Schroeder St.									



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 03560
BIRTH NO. 1. NAME OF DECEASED (Type or Print) <i>Mathews, Bessie</i>		CERTIFICATE OF DEATH 2. DATE AND HOUR OF DEATH <i>4.5.72</i> <i>1 21 P.M.</i>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 39 (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <i>Provident Hospital, Inc.</i> <i>2600 Liberty Height Ave.</i> <i>Baltimore, Md. 21215</i>		4. USUAL RESIDENCE (Where deceased lived, If institution; residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>1303</i> C. CITY OR TOWN <i>Baltimore</i> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <i>2502 Francis St.</i>		
5. SEX <i>Female</i>	6. RACE <i>Black</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Oct. 25, 1922</i>	9. AGE (In years last birthday) <i>49</i>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Domestic</i>		11. BIRTHPLACE (State or foreign country) <i>Charlotte Co. Va.</i>		
13. FATHER'S NAME <i>Johnnie Johnson</i>		14. MOTHER'S MAIDEN NAME <i>Mattie Laines</i>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. 		
17. INFORMANT <i>Samuel Johnson</i>		ADDRESS <i>1826 Clifton Ave.</i>		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE <i>CVA.</i> DUE TO, OR AS A CONSEQUENCE OF: (B) _____ DUE TO, OR AS A CONSEQUENCE OF: (C) _____ II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 		20A. AUTOPSY? (Yes or No) <i>No</i>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		
21F. HOW DID INJURY OCCUR?				
22. I certify that (I) (this hospital) attended the deceased from <i>4-5-1922</i> to <i>4-5-1922</i> that (I) (we) last saw the deceased alive on <i>4-5-1922</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <i>M. J. Shafi</i>				23B. DATE, SIGNED <i>4/6/72</i>
23C. PHYSICIAN'S NAME (Type) <i>M. Shafi, M.D.</i>				23D. ADDRESS
24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>4/12/72</i>		24C. NAME OF CEMETERY or CREMATORY <i>Pleasant Rest Cem.</i>
24D. LOCATION (City, town, or county) (State) <i>Towson Md.</i>				
25A. DATE REC'D BY HEALTH DEPT. <i>APR 13 1972</i>		25B. NAME OF REGISTRAR <i>John E. Jones</i>		25C. FUNERAL DIRECTOR <i>William Samuel Home</i>
				ADDRESS <i>3198 N. Lakeside St.</i>



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 03561	
BIRTH NO. W-452 72 03561		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) Williams, Blanche		2. DATE AND HOUR OF DEATH April 10, 1972 5:08am.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION 39 Provident Hospital 2600 Liberty Height Ave. Baltimore, Md. 21215		A. STATE Maryland		B. COUNTY 1602	
		C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER 1104 Whatcoat St.			
5. SEX Female	6. RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7-10-09	9. AGE (in years last birthday) 62
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY? U.S. A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 220-22-4142		17. INFORMANT Mrs. Emma Muse 1800 Edmondson Mrs. Phyllis Muse 1104 Whatcoat St.	
18. 250.71 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Congestive Heart Failure			
		(B) Chronic Renal Insuff DUE TO, OR AS A CONSEQUENCE OF:			
		(C) Diabetes mellitus			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from January 22, 1972 to April 10, 1972 that (I) (we) last saw the deceased alive on April 10, 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE J. Parker, MD		23B. DATE SIGNED 4-11-72		23C. PHYSICIAN'S NAME (Type) J. Parker	
23D. ADDRESS 2300 Harrison Blvd, Balt, Md		24A. BURIAL CREMATION, REMOVAL (Specify) Burial			
24B. DATE 4-14-72		24C. NAME of CEMETERY or CREMATORY Mt. Auburn Cem.		24D. LOCATION (City, town, or county) (State) Balto., Md.	
25A. DATE REC'D BY HEALTH DEPT. APR 13 1972		25B. NAME OF REGISTRAR Paul E. Fisher, M.D.		25C. FUNERAL DIRECTOR V. Bailey	
				ADDRESS 1348 Calhoun Street	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-400 72 03562				BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 03562	
BIRTH NO.				1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
				Bell, Georgia A.		April 9, 72 5-55 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE B. COUNTY			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				Maryland			
Bon Secours Hospital 34 2025 W. Fayette Street Baltimore, Maryland 21223				C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER				1400 W. Franklin Street			
5. SEX Female		6. RACE Black		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 03-11-04	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		9. AGE (In years last birthday) 68		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME James Cole				14. MOTHER'S MAIDEN NAME United States.			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. 212324071		17. INFORMANT SARAH GREEN 1352 W. NORTH AVE.	
18. 430.0 IF 174X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshtenio, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) IMMEDIATE CAUSE Subarachnoid + intracerebral hemorrhage (B) Hypertension (C)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 day years	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). Co of left breast w/ axillary nodes				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH months			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indify medical examined)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 4-9-72 to 4-9-72 that (I) (we) last saw the deceased alive on 4-9-72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Malinee Yungting M.D.				23B. DATE SIGNED 4-9-72			
23C. PHYSICIAN'S NAME (Type) MALINEE YUNGTING M.D.				23D. ADDRESS 2025 W. FAYETTE ST. BALTO.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4-14-72		24C. NAME OF CEMETERY OR CREMATORY Mt. Auburn Cem.		24D. LOCATION (City, town, or county) (State) Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT. APR 13 1972		25B. NAME OF REGISTRAR John E. Bailey M.D.		25C. FUNERAL DIRECTOR Bailey		ADDRESS 1348 Calhoun Street	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				72 03563	
CERTIFICATE OF DEATH				REG. NO. 72 03563	
BIRTH NO. <u>W 630</u>		1. NAME OF DECEASED (Type or Print) <u>COLE WORTHY SR.</u>			
2. DATE AND HOUR OF DEATH <u>4/10/72</u>		19:05 PM M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>UNIVERSITY HOSPITAL</u>		A. STATE <u>MD.</u>		B. COUNTY <u>BALTO CITY</u>	
		C. CITY OR TOWN <u>BALTIMORE</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER <u>322 N. STRICKER ST.</u>			
5. SEX <u>M</u>	6. RACE <u>N</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6/10/100</u>	9. AGE (In years last birthday) <u>71</u>	10. Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ret.</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>City Hospital</u>		11. BIRTHPLACE (State or foreign country) <u>S.C.</u>	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>212125273A</u>		17. INFORMANT ADDRESS <u>Cole Worthy Jr. Wash., D.C.</u>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE <u>CARDIORESPIRATORY</u>		<u>1 dy</u>	
ANTECEDENT CAUSES		(B) <u>EXTRADURAL HEMANGIOMA T</u>		<u>7</u>	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) _____		_____	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION <u>4/3/72</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>PARAPLEGIA</u>		20A. AUTOPSY? (Yes or No) <u>NO</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <u>(H)</u> (this hospital) attended the deceased from <u>3/31</u> 19 <u>72</u> to <u>4/10</u> 19 <u>72</u> that <u>(H)</u> (we) last saw the deceased alive on <u>4/10</u> 19 <u>72</u> and that <u>(H)</u> (my) (our) opinion death occurred on the date and hour and from the causes stated above. <u>(H)</u> (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>L. B. Barnett MD</u>		23B. DATE SIGNED <u>4/10/72</u>		23C. PHYSICIAN'S NAME (Type) <u>L. B. BARNETT MD</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>4-14-72</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Mt. Auburn Cem.</u>	
24D. LOCATION (City, town, or county) <u>Balto., Md.</u>		24E. ADDRESS <u>UNIVERSITY HOSPITAL</u>			
25A. DATE REC'D BY HEALTH DEPT. <u>APR 13 1972</u>		25B. NAME OF REGISTRAR <u>J. E. E. E. E. E.</u>		25C. FUNERAL DIRECTOR <u>V. Bailey</u> ADDRESS <u>1348 Calhoun Street</u>	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				72 03564		72 03564	
CERTIFICATE OF DEATH				REG. NO. _____			
1. NAME OF DECEASED (Type or Print) <u>Vernon Lloyd</u>		2. DATE AND HOUR OF DEATH <u>4/12/72</u> <u>3:30 A.M.</u>					
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <u>Bon Secours Hospital</u>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Md</u> B. COUNTY <u>2005</u>			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>Bon Secours Hospital</u>				C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <u>418 S. Bentallou St. Balto 21223</u>			
5. SEX <u>M</u>	6. RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>09/21/11</u>	9. AGE (In years last birthday) <u>60</u>	If Under 1 Yr. Months: Days: Hours: Min.	If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Supervisor</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Electrician</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William Lloyd</u>				14. MOTHER'S MAIDEN NAME (Duchner) <u>Mary E. Duchner</u> (deceased)			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service <u>Yes</u> <u>WW 2</u>		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <u>Mrs. Mary Lloyd, 418 S. Bentallou Street</u>			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Respiratory failure</u> <u>lung cancer</u>				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>wk.</u> <u>years</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).							
19A. DATE OF OPERATION <u>0-7-19</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>March 29, 1972</u> to <u>April 12, 1972</u> that (I) (we) last saw the deceased alive on <u>April 12, 1972</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>Bandith</u> M.D.				23B. DATE SIGNED		23C. PHYSICIAN'S NAME (Type) <u>Bandith</u> M.D.	
23D. ADDRESS <u>Bon Secours Hospital</u>				23E. DATE SIGNED		23F. PHYSICIAN'S NAME (Type) <u>Bandith</u> M.D.	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>4/15/72</u>		24C. NAME OF CEMETERY or CREMATORY <u>Western Cemetery</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>APR 13 1972</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor, M.D.</u>		25C. FUNERAL DIRECTOR <u>Witzke, 13630</u>		25D. ADDRESS <u>Edmondson Avenue 21228</u>	

1917

1918

1919

1920

1921

1922

1923

1924

1925

1926

1927

1928

1929

1930

1931

1932

1933

1934

1935

1936

1937

1938

1939

1940

1941

1942

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

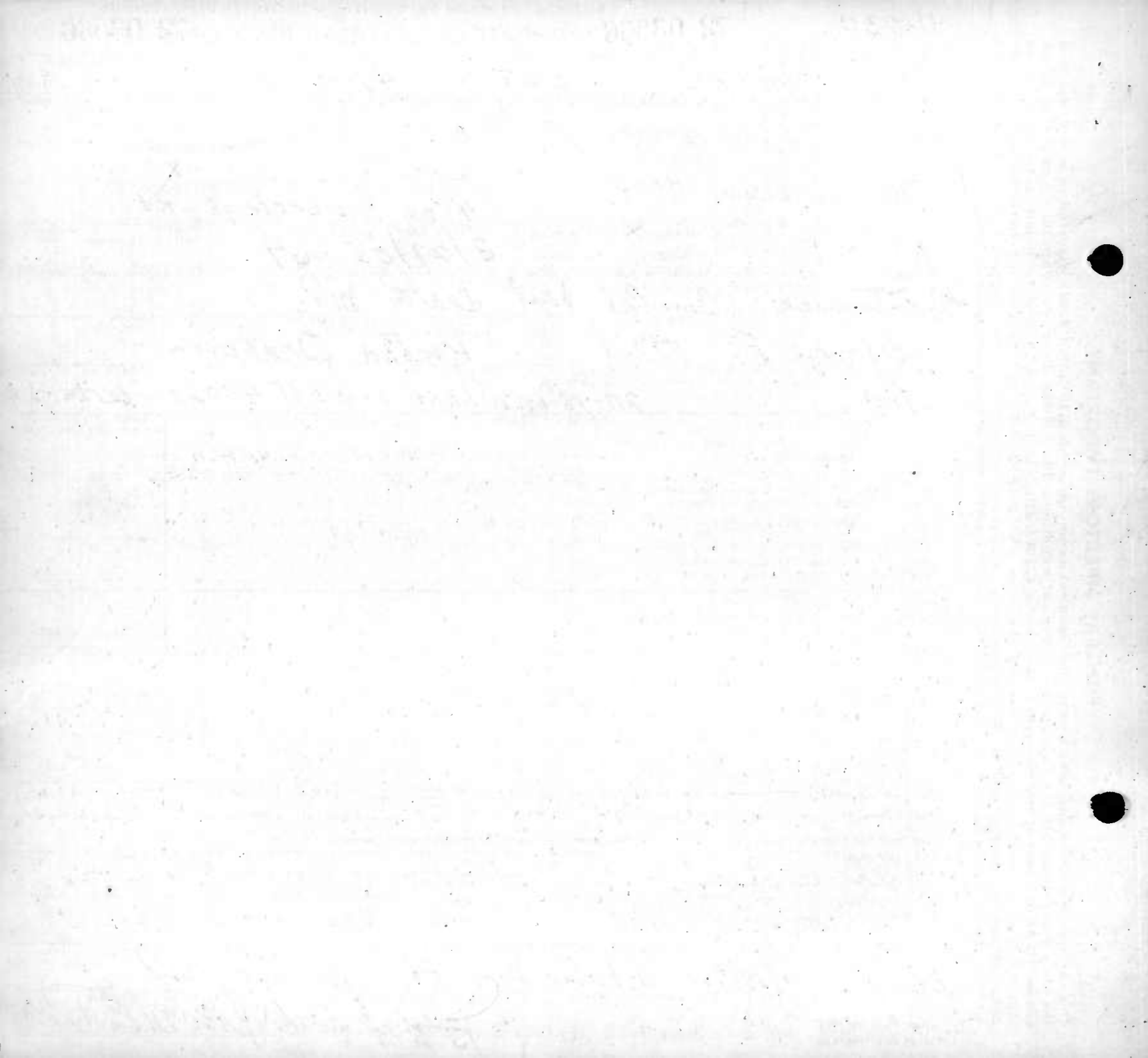
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>72 03565</u>	
BIRTH NO. <u>B-650</u>		72 03565		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) BORN MARIE ELIZABETH			2. DATE AND HOUR OF DEATH APRIL 12 1972 10:25AM M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 40 ST AGNES HOSPITAL			4. USUAL RESIDENCE (Where deceased lived. If institution residence before admission) A. STATE MARYLAND B. COUNTY 2854 C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 12 N TREMONT ROAD 21229		
5. SEX FEMALE	6. RACE CAUCASIAN	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/08/02	9. AGE (In years last birthday) 69	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U S A			13. FATHER'S NAME WILLIAM HARMAN		
14. MOTHER'S MAIDEN NAME MARY SELLMAN			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		
16. SOCIAL SECURITY NO. 216-32-7879B		17. INFORMANT ADDRESS ST AGNES HOSPITAL BALTO MD 21229			
18. 411.9 I CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. (A) IMMEDIATE CAUSE Severe Coronary Insufficiency DUE TO, OR AS A CONSEQUENCE OF: PNEUMONIA (B) CONGESTIVE HEART FAILURE DUE TO, OR AS A CONSEQUENCE OF: (C) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 04/11/72 19 to 04/12/72 19 that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 04/12/72 19 and that <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) (did) <input checked="" type="checkbox"/> view the body after death.					
23A. SIGNATURE <i>Madhu John</i>				23B. DATE SIGNED 4/12/72	
23C. PHYSICIAN'S NAME (Type) MADHU JOHN MD				23D. ADDRESS ST AGNES HOSPITAL BALTO MD 21229	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4/15/72		24C. NAME OF CEMETERY or CREMATORY Wards Chapel	
24D. LOCATION (City, town, or county) (State) Carroll County, Maryland		25A. DATE REC'D BY HEALTH DEPT. APR 13 1972			
25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR ADDRESS Witzke, 1630 Edmondson Avenue 21228			

Chas. G. Davis

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

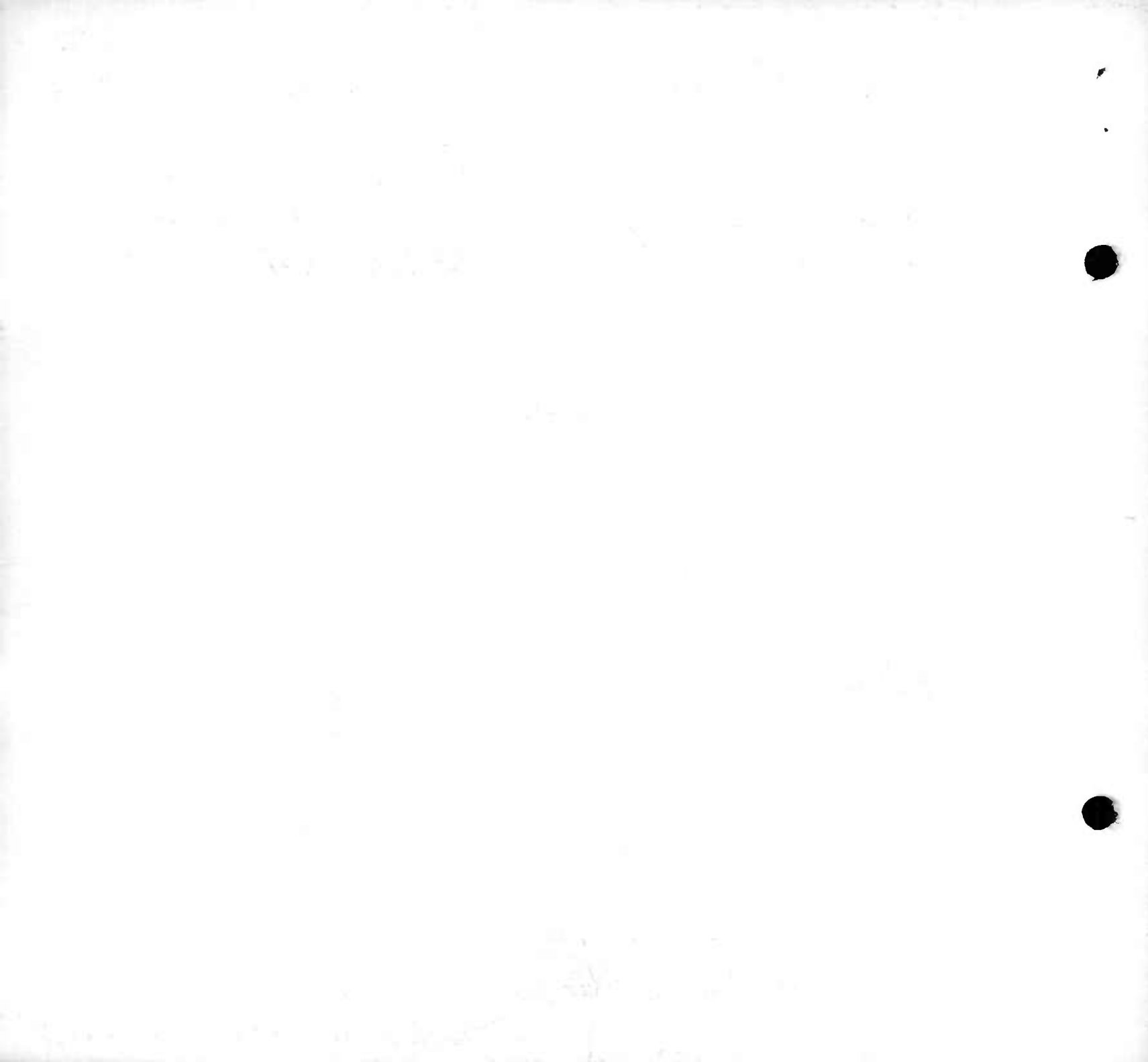
U-230 72 03566		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 03566	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		JAMES WEST		4/12/72 6 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 44 UNION MEM. HOSP				A. STATE Md.	
				B. COUNTY 2710	
				C. CITY OR TOWN BALTO.	
				D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER 4802 Kimberleigh Rd	
5. SEX M	6. RACE C	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3/27/05	9. AGE (In years lost birthday) 67
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Maintenance		10B. KIND OF BUSINESS OR INDUSTRY Brown Pkx deal		11. BIRTHPLACE (State or foreign country) Balto. Md	
13. FATHER'S NAME George F. West				14. MOTHER'S MAIDEN NAME Rintha Dreher	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 217-18-6458		17. INFORMANT CLARA I. WEST 4802 Kimberleigh Rd	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH CANCER STOMACH ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION O		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from about 1965 to about 4-10 1972, that (I) (we) last saw the deceased alive on about Mar 19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Jerome Gader				23B. DATE SIGNED 4-12-72	
23C. PHYSICIAN'S NAME (Type) JEROME GADER				23D. ADDRESS 5706 BELLONA AV 21212	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4/15/72		24C. NAME OF CEMETERY or CREMATORY Anteburial Mem. PK Anteburial Md	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR Joseph J. Rock 1304 N. Central St	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

C-652		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 03567	
BIRTH NO. 72 03567		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) Nina O. Cornish		2. DATE AND HOUR OF DEATH 4/11/72 1 54⁵ A M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MD. B. COUNTY 833			
FULL NAME OF HOSPITAL OR INSTITUTION JOHNS HOPKINS HOSPITAL		C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		E. STREET AND NUMBER 1311 N. LUZERNE AVE.			
5. SEX F	6. RACE N	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/29/08	9. AGE (in years last birthday) 64	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) DOMESTIC		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) CAMBRIDGE, MD	
13. FATHER'S NAME JOHN WESLEY STANLEY		14. MOTHER'S MAIDEN NAME LUCY JOHNSON			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 220-12-4930		17. INFORMANT HUSBAND	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) UREMIA ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) slowing the UNDERLYING CONDITION lost.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Adenocarcinoma of the ovary (B) DUE TO, OR AS A CONSEQUENCE OF: (C)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 7 days	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 3/2/72		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED occlusion of ureters		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (this hospital) attended the deceased from March 23 19 72 to April 11 19 72 that (we) last saw the deceased alive on April 11 19 72 and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE T. J. Horrigan MD				23B. DATE SIGNED 4/11/72	
23C. PHYSICIAN'S NAME (Type) Terrence J. Horrigan, MD.				23D. ADDRESS The Johns Hopkins Hospital	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4/15/72		24C. NAME OF CEMETERY OR CREMATORY Arturus Mem. Pk	
24D. LOCATION (City, town or county) (State) Arturus, Md		25A. DATE DEATH CERT. ISSUED APR 13 1972			
25B. NAME OF REGISTRAR Joseph B. Lock		25C. FUNERAL DIRECTOR 13047 Central Ave			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO. 72 03568

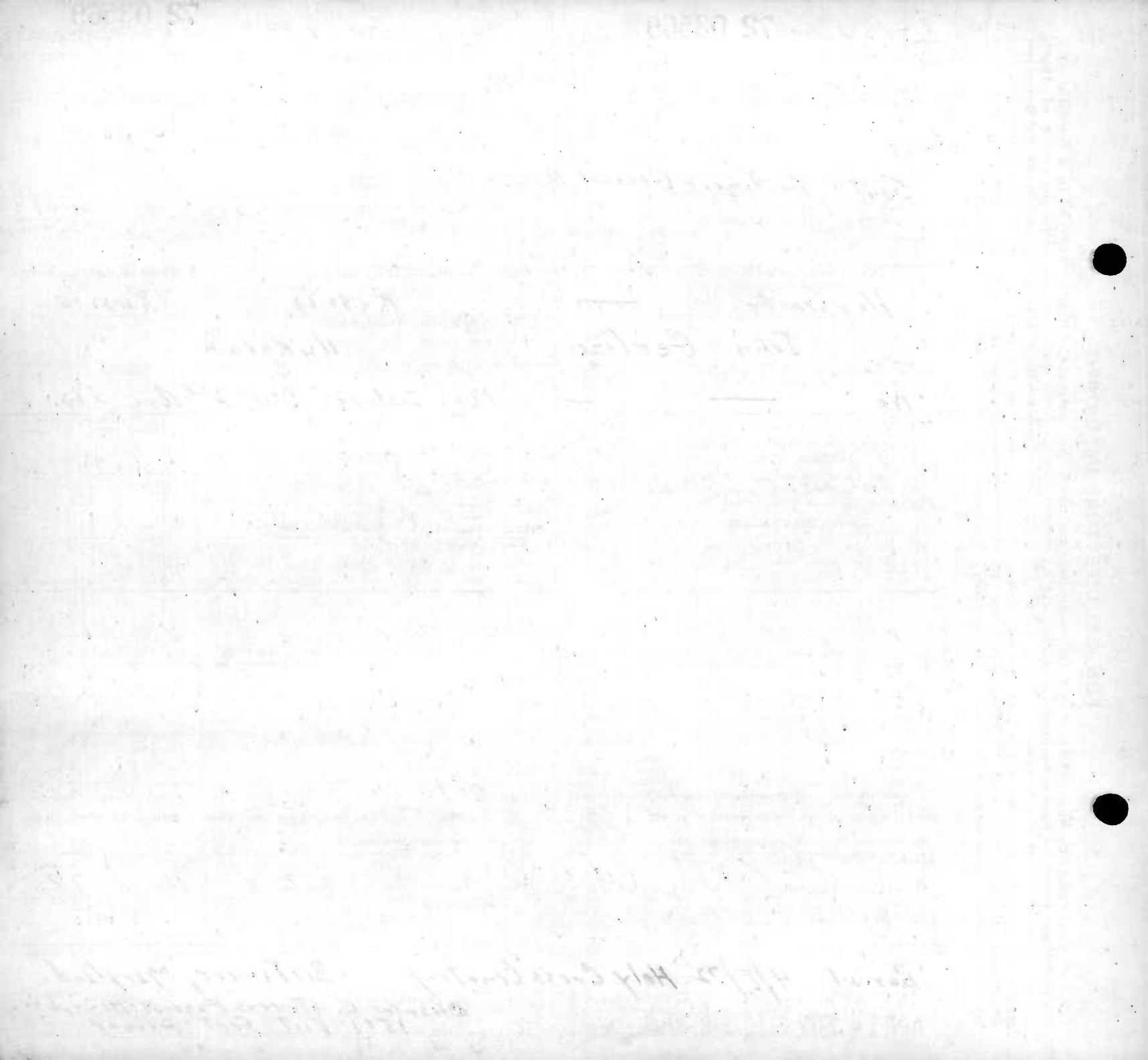
BIRTH NO. 72 03568		1. NAME OF DECEASED (Type or Print) <u>Jerry F. Wilder</u>		2. DATE AND HOUR OF DEATH <u>4-10-72</u> <u>4:30 PM</u> M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>1512</u>		
FULL NAME OF HOSPITAL OR INSTITUTION <u>Provident Hospital Inc.</u>			C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
E. STREET AND NUMBER <u>2809 Violet Avenue</u>					
5. SEX <u>MALE</u>	6. RACE <u>Negro</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MARCH 1, 1948</u>	9. AGE (in years last birthday) <u>24</u>	10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY <u>Balto. Public Schools</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>					
13. FATHER'S NAME <u>SAMUEL Wilder</u>			14. MOTHER'S MAIDEN NAME <u>Pearl Wilson</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>214-50-6470</u>		17. INFORMANT ADDRESS <u>JANICE Wilder 2809 Violet Ave.</u>	
18. <u>430.71</u> CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Cardio-Respiratory Failure</u>		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(B) <u>Subarachnoid Hemorrhage</u> DUE TO, OR AS A CONSEQUENCE OF: <u>5 days</u>		
(C) _____					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <u>Seizure Disorder, Asthma</u>					
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY (Yes or No) <u>YES</u>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>NO</u>					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>4-6-72</u> 19 <u>72</u> to <u>4-10</u> 19 <u>72</u> that (I) (we) last saw the deceased alive on <u>4-10</u> 19 <u>72</u> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>M. J. S. [Signature]</u>			23B. DATE SIGNED <u>4/11/72</u>		
23C. PHYSICIAN'S NAME (Type) DEGREE			23D. ADDRESS DEGREE		
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>4/14/72</u>		24C. NAME OF CEMETERY or CREMATORY <u>Arbutus Memorial</u>	
24D. LOCATION (City, town, or county) (State) <u>Arbutus (Baltimore Co.) Md.</u>					
25A. DATE REC'D BY HEALTH DEPT. <u>APR 13 1972</u>		25B. NAME OF REGISTRAR <u>Robert E. [Signature]</u>		25C. FUNERAL DIRECTOR (Address) <u>Harford Ave.</u>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Baltimore City Health Department				REG. NO. 72 03569	
7-100 72 03569		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) ZIPP ELIZABETH M.		2. DATE AND HOUR OF DEATH 4-5-72 11 P M.			
3. PLACE IN BALTIMORE MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MD. B. COUNTY A.A.C.			
FULL NAME OF HOSPITAL OR INSTITUTION 43 South Baltimore General Hospital		C. CITY OR TOWN Glen Burnie		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
FULL ADDRESS OR LOCATION 604 Second Ave		E. STREET AND NUMBER 21061			
5. SEX F.	6. RACE W.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 5-18-95	9. AGE (In years last birthday) 76
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY —		11. BIRTHPLACE (State or foreign country) Russia	
12. CITIZEN OF WHAT COUNTRY? Russia		13. FATHER'S NAME John Gerling		14. MOTHER'S MAIDEN NAME Unknown	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. —		17. INFORMANT Mary Zaleski	
18. 199.0 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Carcinomatosis		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: metastatic adenocarcinoma (?)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 mos.	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). pneumonia			
19A. DATE OF OPERATION 3-27-72		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED intestinal obstruction		20A. AUTOPSY? (Yes or No) yes	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? yes		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from 3-10-72 19 72 to 4-5 19 72 , that (I) (we) last saw the deceased alive on 4-5 19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE Richard H. Friedman		23B. DATE SIGNED 4-6-72		23C. PHYSICIAN'S NAME (Type) Richard H. Friedman	
23D. ADDRESS 536 H		24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4/8/72	
24C. NAME OF CEMETERY or CREMATORY Holy Cross Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland		25A. DATE REC'D BY HEALTH DEPT. APR 13 1972	
25B. NAME OF REGISTRAR Charles E. Stevens		25C. FUNERAL DIRECTOR Charles E. Stevens		25D. ADDRESS 1501 East Fort Avenue	



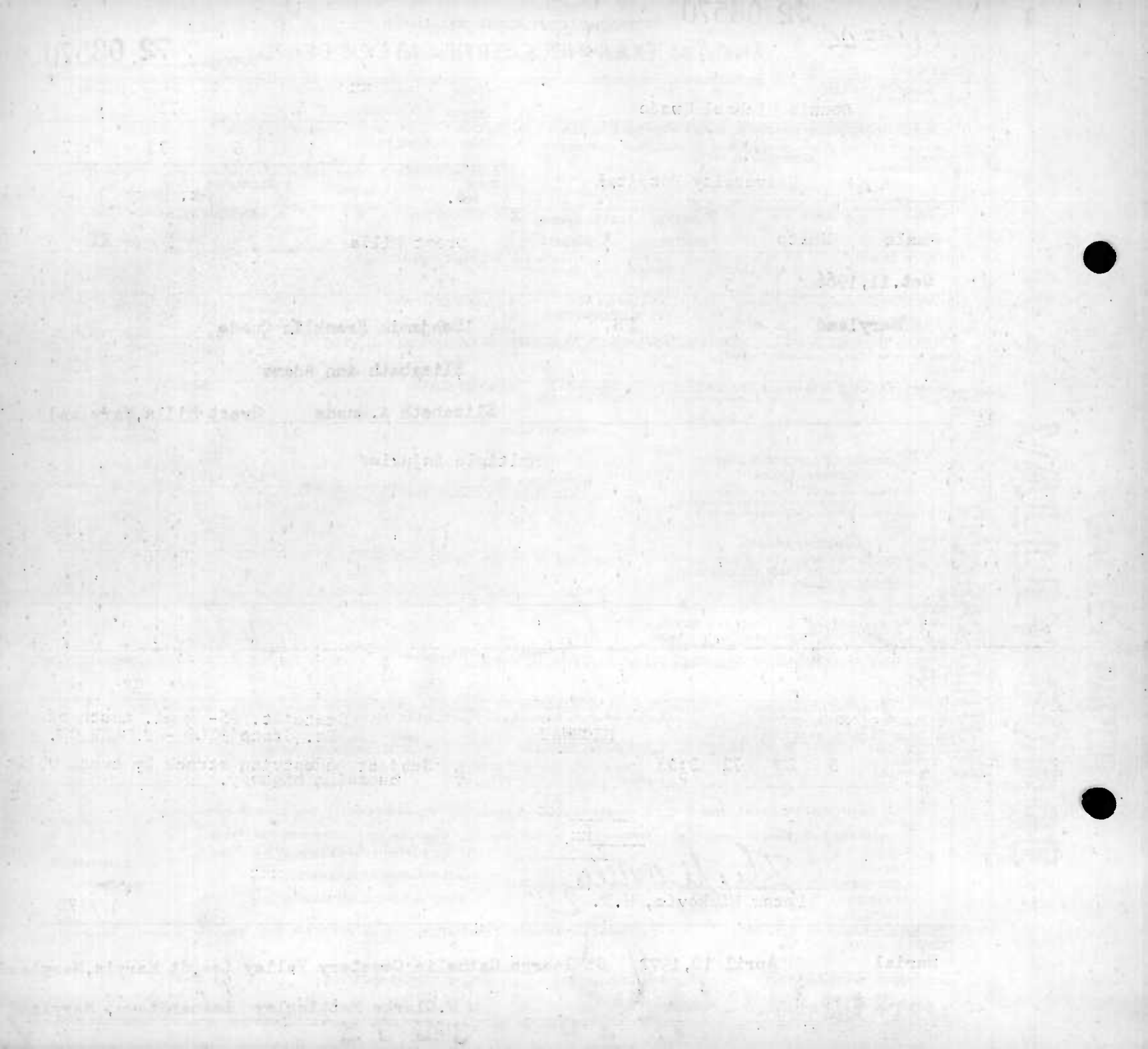
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

72 03570

BIRTH NO. *Q-300 St Marys Co. Md.*

1. NAME OF DECEASED (Type or Print) Dennis Michael Quade		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year 4 6 72		Hour M.
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD (If not in hospital or institution, give street address or location) University Hospital		3. DATE PRONOUNCED DEAD Month Day Year 4 6 72		Hour 9:27 P.
6. SEX male		7. RACE White		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
9. DATE OF BIRTH Oct. 11, 1966		10. AGE (In years last birthday) 5		11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF US		13. FATHER'S NAME Benjamin Franklin Quade		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
15. MOTHER'S MAIDEN NAME Elizabeth Ann Adams		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO.
18. INFORMANT Elizabeth A. Quade		ADDRESS Great Mills, Maryland		19. CAUSE OF DEATH Multiple injuries
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) no
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) HIGHWAY		22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) State Rt. #5 - 1/2 mi. north of Rt. State #246 - ST MARY CO.
22D. TIME OF INJURY (APPROX.) Month Day Year 3 29 72		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> 3:55 P. m.		22F. HOW DID INJURY OCCUR? Subject pedestrian struck by truck while crossing highway.
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <i>Peter Lipkovic</i> M.D. EXAMINER'S NAME (Type) Peter Lipkovic, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 4/7/72				
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE April 10, 1972		24C. NAME of CEMETERY or CREMATORY St George Catholic Cemetery Valley Lee, St Mary's, Maryland
24D. LOCATION (City, town, or county) (State) Leonardtown, Maryland		25A. DATE REC'D BY HEALTH DEPT. APR 13 1972		25B. NAME OF REGISTRAR Robert E. Fisher, M.D.
25C. FUNERAL DIRECTOR W. Clarke Mattingley		25D. ADDRESS Leonardtown, Maryland		



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

72 03571

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Willie O. Booker (Mosley)		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month 4 Day 11 Year 72 Hour M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 33 Johns Hopkins Hospital		3. DATE PRONOUNCED DEAD Month 4 Day 11 Year 72 Hour 5:55 p. M.	
5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Md. B. COUNTY 806			
6. SEX male	7. RACE Negro	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH 6-8-43		10. AGE (In years last birthday) 28 If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) Buckingham, Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer-Technician		14B. KIND OF BUSINESS OR INDUSTRY J.H.H.	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no		17. SOCIAL SECURITY NO.	
18. INFORMANT Mrs. Mary Bouldin 2202 N. Calvert St. 21218 Mrs. Shirley Mosley 1635 E. North Ave. 21213		ADDRESS	
19. CAUSE OF DEATH 2-966 X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Bond and Lafayette Sts.	
22D. TIME OF INJURY (APPROX.) Month 4 Day 11 Year 72 Hour 5:35 p.m.		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	
22C. WHERE DID IT IN BALTIMORE CITY, GIVE EXACT LOCATION) Bond and Lafayette Sts.		22F. HOW DID INJURY OCCUR? Subject stabbed by unknown assailant.	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Peter Lipkovic, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) Peter Lipkovic, M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED 4/12/72 ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 4-15-1972	24C. NAME OF CEMETERY or CREMATORY Arbutus Memorial Park	24D. LOCATION (City, town, or county) (State) Baltimore, Maryland
25A. DATE REC'D BY HEALTH DEPT. APR 13 1972		25B. NAME OF REGISTRAR Robert E. Fisher, M.D.	25C. FUNERAL DIRECTOR 1735 Harford Ave. 21213 Marshall W. Jones, Jr.

1770 S.

WILSON D. JONES (1917-1973)

1917-1973

Washington, Virginia

Inspector-Technician (1973-1975)

Very Good

Mr. Jones was assigned to the position of Inspector-Technician in the Washington, Virginia office of the Federal Bureau of Investigation (FBI) in 1973. He was assigned to the position of Inspector-Technician in the Washington, Virginia office of the Federal Bureau of Investigation (FBI) in 1973.

ACADEMY

4-15-1973

Arthur Memorial Park

Washington, Virginia

1973-1975

Washington, D.C.

FUNERAL DIRECTOR: IMPORTANT

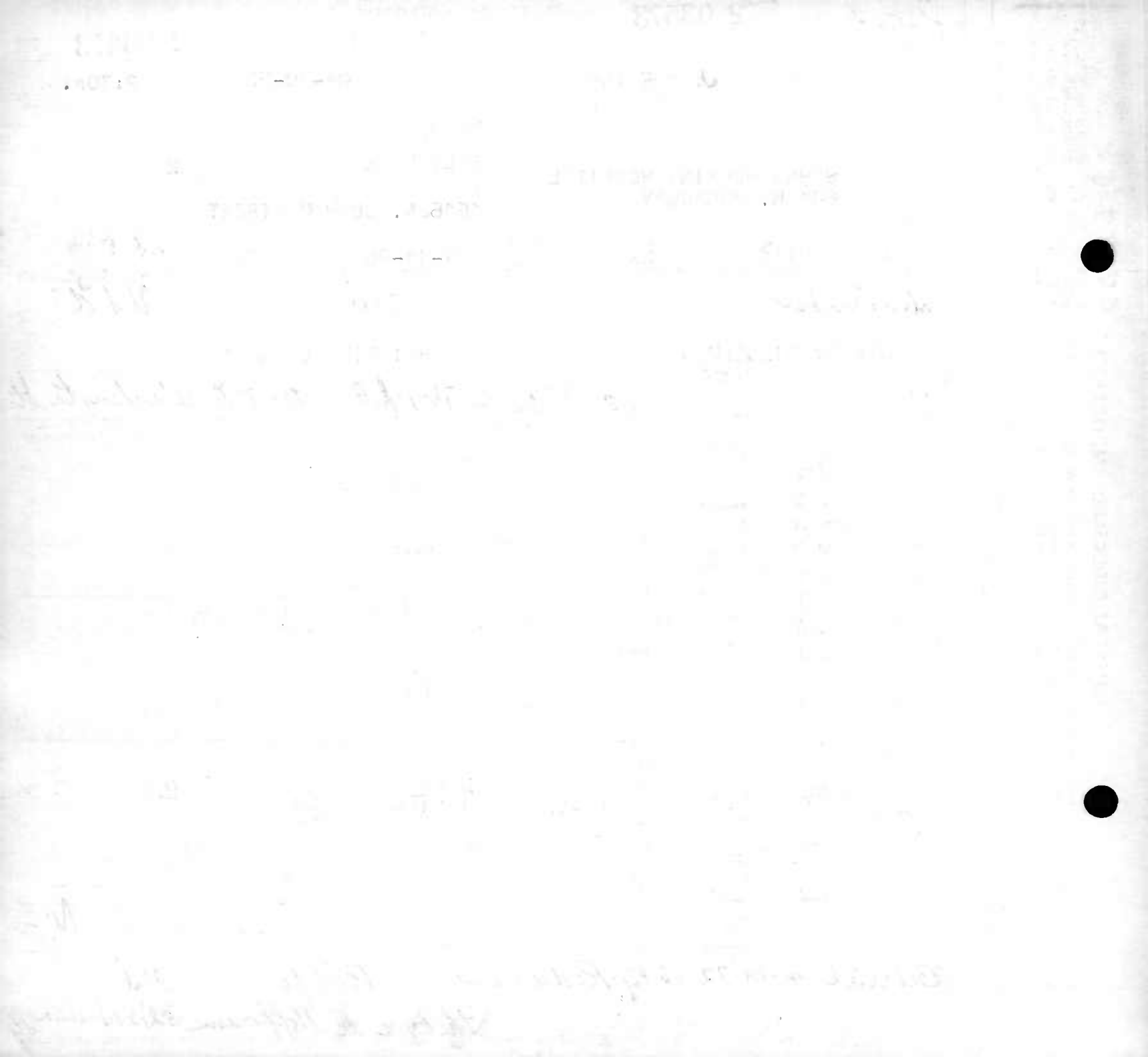
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

A-200		72 03572		BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		X REG. NO. 72 03572	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) DAVID S. HICKS.				2. DATE AND HOUR OF DEATH 4-11-72 8:00 A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD B. COUNTY BALTO.				5. STREET AND NUMBER 445 LAMBERT COURT. 21227.			
FULL NAME OF HOSPITAL OR INSTITUTION SINAI HOSPITAL OF BALTIMORE.		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) BELVEDERE AT GREENSPRING BALTIMORE 21215				C. CITY OR TOWN BALTIMORE.		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX M	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7-27-59.	9. AGE (in years last birthday) 12	10. UNDER 1 Yr. Months Days		11. UNDER 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) STUDENT		10B. KIND OF BUSINESS OR INDUSTRY School		11. BIRTHPLACE (State or foreign country) MARYLAND.		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME GEORGE D. HICKS Jr.				14. MOTHER'S MAIDEN NAME BETTY BANNER.					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. none		17. INFORMANT Mr George D. Hicks		ADDRESS AS ABOVE #4			
18. 776.9 I		CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Disseminated Infection.				1 yr.			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) Chronic Granulomatous Disease				12 yrs.			
(C)									
II									
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).									
19A. DATE OF OPERATION 4-1-72		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Spinal Abscess		20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? NO.			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR?		(If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from 12-27-1971 to 4-11-1972 that (I) (we) last saw the deceased alive on 4-10-1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE Angela White M.B.C.B.				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 4-11-72			
23C. PHYSICIAN'S NAME (Type) ANGELA WHITE.				23D. ADDRESS SINAI HOSPITAL OF BALTIMORE.					
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 4/14/72		24C. NAME of CEMETERY or CREMATORY Evergreen Cemetery		24D. LOCATION (City, town, or county) (State) Erwin Tenn.			
25A. DATE REC'D BY HEALTH DEPT. APR 13 1972		25B. NAME OF REGISTRAR 2238		25C. FUNERAL DIRECTOR W. R. Brown		ADDRESS Singletary Funeral Home, 6411 Rivington Rd.			

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Baltimore City Health Department				REG. NO. 72 03573	
BIRTH NO. R-563		72 03573		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) MARY EUGEN REINHARDT			2. DATE AND HOUR OF DEATH 04-10-72 2:30 P. M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION 33 JOHNS HOPKINS HOSPITAL 601 N. BROADWAY			A. STATE MARYLAND B. COUNTY 806		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER 1616 N. DURHAM STREET		
5. SEX FEMALE	6. RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 02-11-98	9. AGE (In years last birthday) 74	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Md	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME ANTHONY DIEGELMAN			
14. MOTHER'S MAIDEN NAME CHRISTINE UNKNOWN				15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No	
16. SOCIAL SECURITY NO. 218-52-0710		17. INFORMANT C. Nappel 1608 N. Washington St. ADDRESS			
18. CAUSE OF DEATH			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Pulmonary embolism 5 hr		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(B) DUE TO, OR AS A CONSEQUENCE OF:		
(C)					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			Atrial Fibrillation; ASCVD Chronic		
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 4/7 to 4/10 1972 and that (I) (we) last saw the deceased alive on 4/10 1972 and that (I) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE W. Rohde			23B. DATE SIGNED 4/10/72		
23C. PHYSICIAN'S NAME (Type) W. ROHDE			23D. ADDRESS 601 N. Broadway Balto Md.		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4-14-72		24C. NAME of CEMETERY or CREMATORY Holy Redeemer	
24D. LOCATION Balto. Md.		25A. DATE REC'D BY HEALTH DEPT. APR 13 1972			
25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR Theodor M. Hoffmann		ADDRESS 3218 N. Union St.	



R-252
Reisinger

72 03574

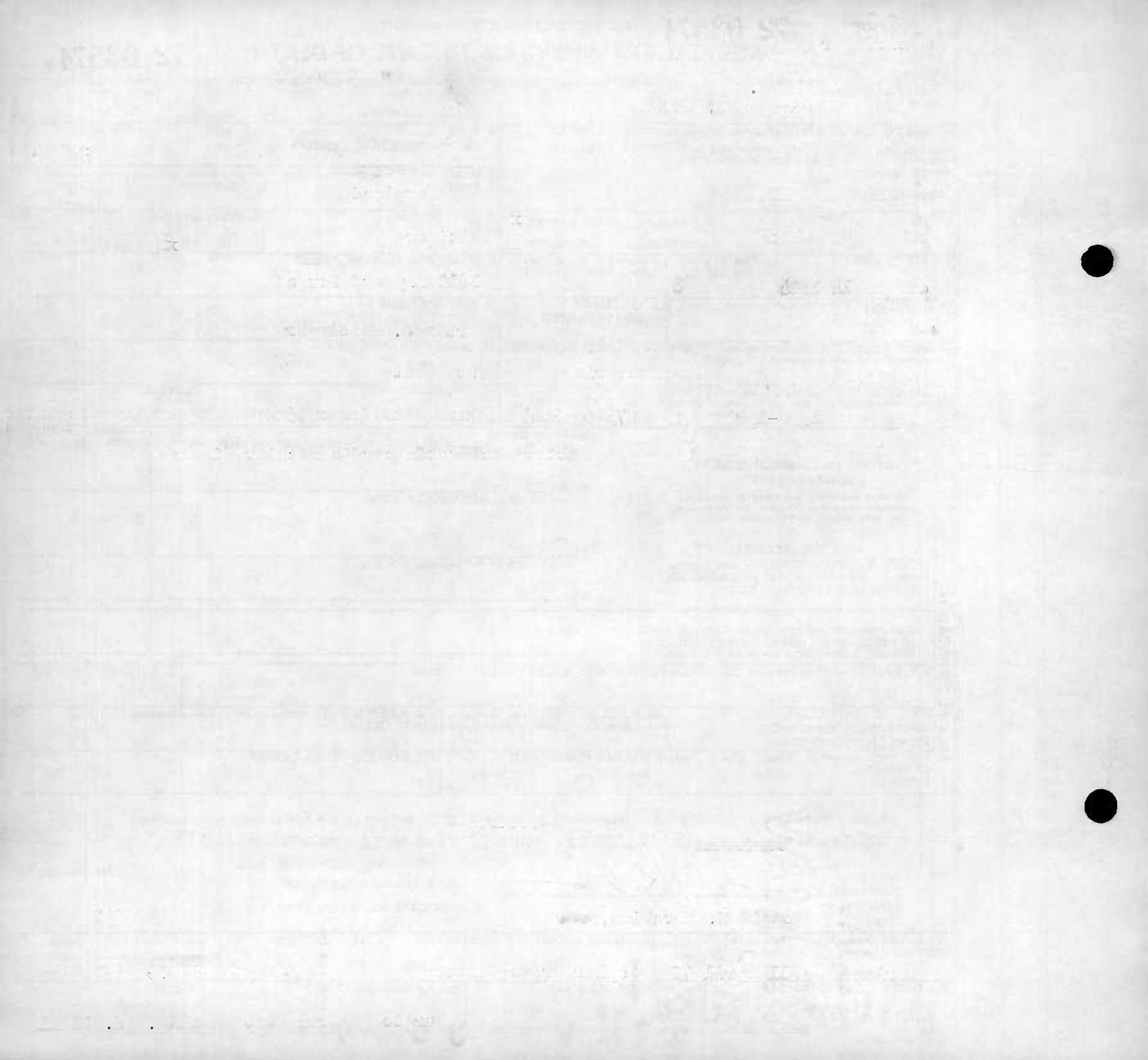
BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 72 03574

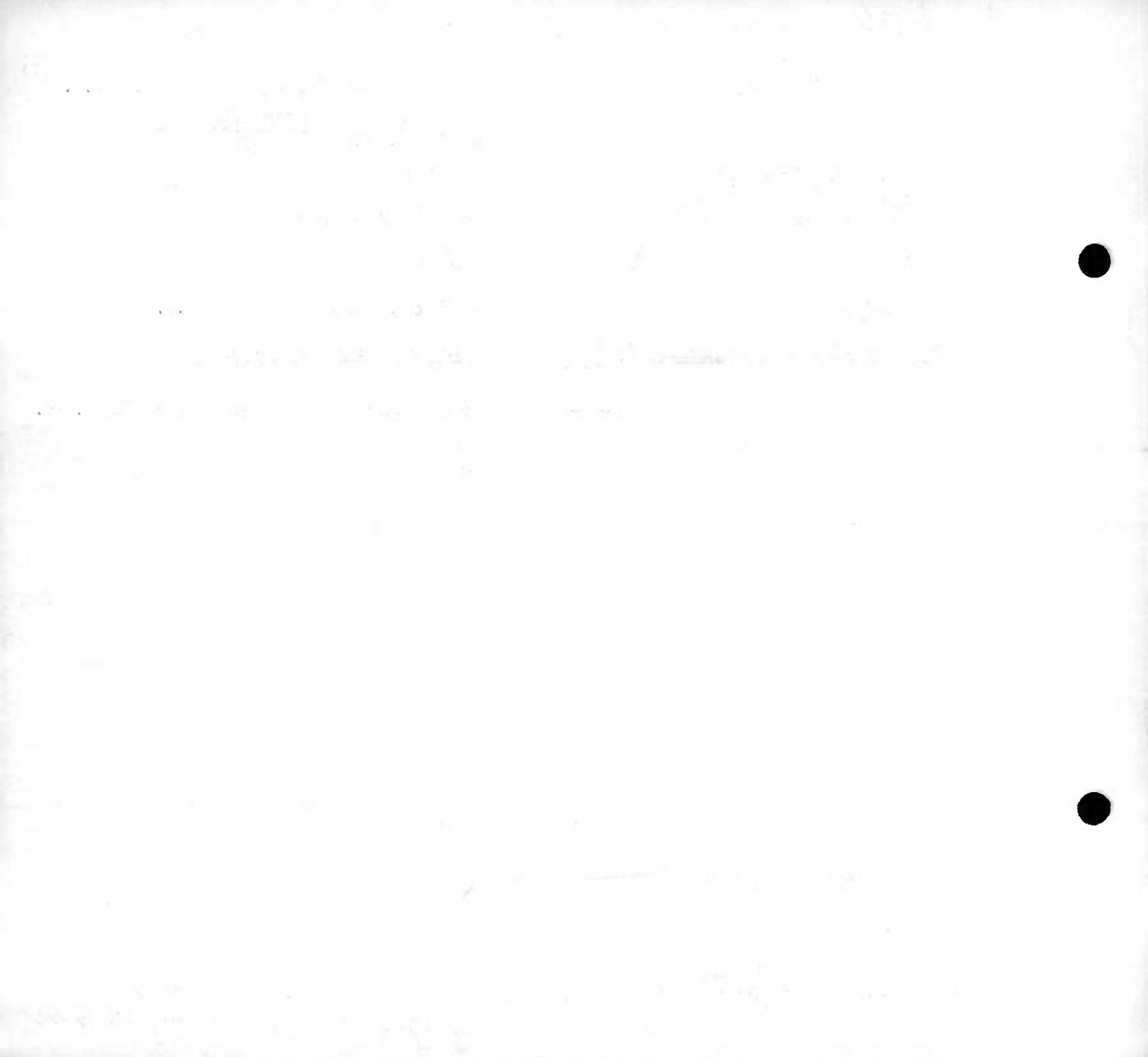
BIRTH NO.

1. NAME OF DECEASED (Type or Print) EDGAR REISINGER		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 42 SINAI HOSPITAL		3. DATE PRONOUNCED DEAD Month Day Year Hour April 4, 1972 5:00 P.M.	
5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 2788			
6. SEX Male	7. RACE White	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
9. DATE OF BIRTH October 14 1913		10. AGE (In years last birthday) 58	E. STREET AND NUMBER 3612 Hayward Street
11. BIRTHPLACE (State or foreign country) New York		12. CITIZEN OF WHAT COUNTRY? USA	13. FATHER'S NAME Martin J. Reisinger
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machinist		14B. KIND OF BUSINESS OR INDUSTRY Manufacturing	15. MOTHER'S MAIDEN NAME Lucy Voit
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) Yes 1938-1943		17. SOCIAL SECURITY NO. 073 05 3543	18. INFORMANT Thomas Reisinger 936 Genese Pk Blvd Rochester NY
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease DUE TO, OR AS A CONSEQUENCE OF: (A) IMMEDIATE CAUSE (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) yes			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?			
22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?			
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <i>Ronald N. Kornblum</i> M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) Ronald N. Kornblum, M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED 4/5/72 ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 11 April 72	24C. NAME OF CEMETERY or CREMATORY Poplar Grove Cemetery	24D. LOCATION (City, town, or county) (State) Baltimore County, Maryland
25A. DATE REC'D BY HEALTH DEPT. APR 13 1972	25B. NAME OF REGISTRAR Robert E. Taylor, M.D.	25C. FUNERAL DIRECTOR Banjee Funeral Home	ADDRESS Balto. Md. 21211



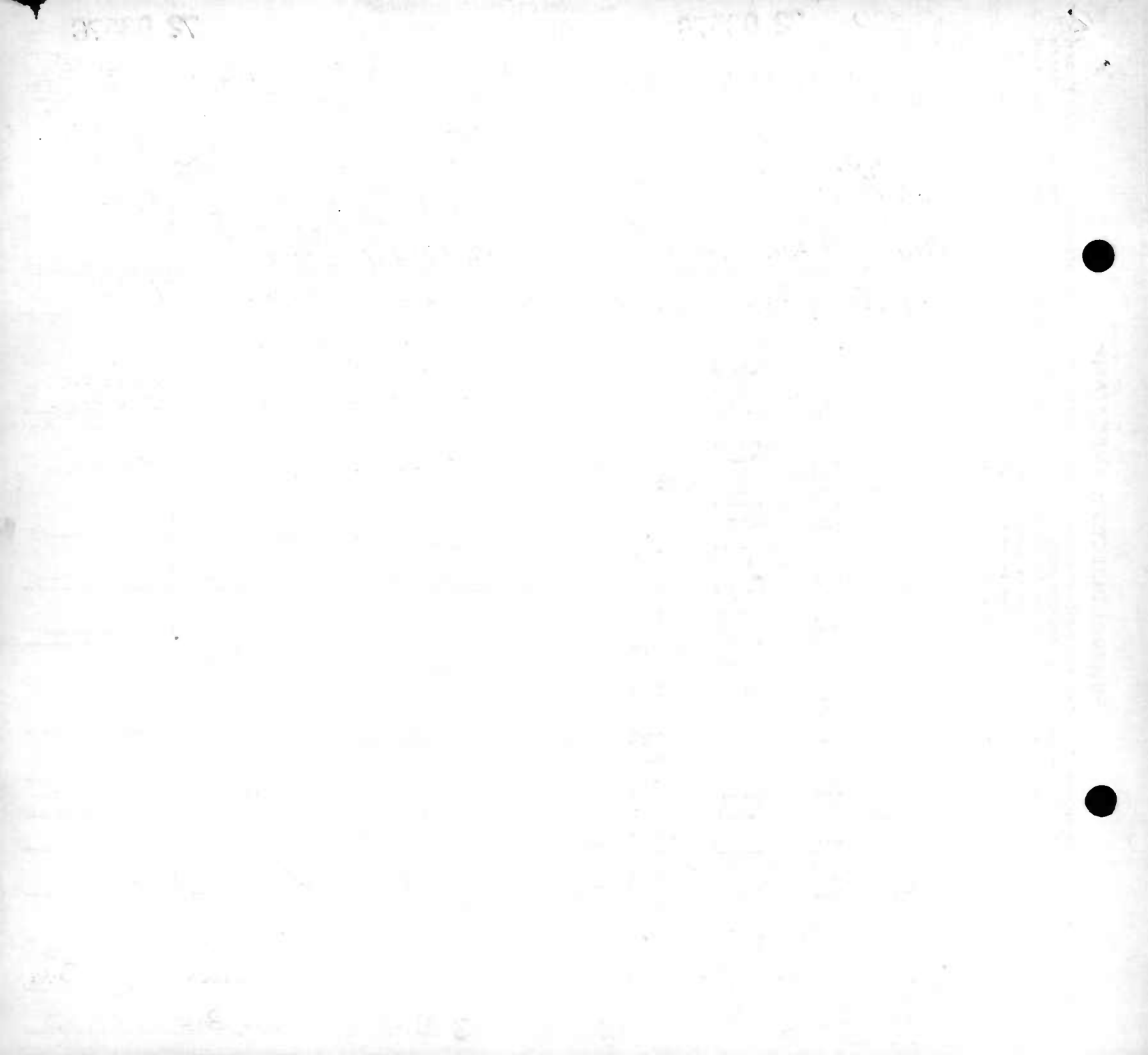
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 3959
A-536		72 03575		72 03575
BIRTH NO.		M.		
1. NAME OF DECEASED (Type or Print) <i>Eugenia Andrews</i>		2. DATE AND HOUR OF DEATH <i>April 11, 1972 2:30 p.m.</i>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <i>House In The Pines Belvedere 2525 West Belvedere Avenue Baltimore, Maryland 21215</i>		A. STATE <i>Baltimore, Maryland</i> B. COUNTY <i>3838 Roland Avenue 21215</i>		
		C. CITY OR TOWN <i>Baltimore</i>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
		E. STREET AND NUMBER <i>3838 Roland Avenue</i>		
5. SEX <i>F</i>	6. RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>8/25/82</i>	9. AGE (In years last birthday) <i>89</i>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>House wife</i>		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <i>Baltimore, Maryland</i>	12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>
13. FATHER'S NAME <i>Frank/Andrews George Andrews Wise</i>		14. MOTHER'S MAIDEN NAME <i>Albertina Wise WALTER</i>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>217-48-1437</i>		17. INFORMANT ADDRESS <i>Albert Andrews 3339 Beech Avenue Balto. Md.</i>
18. <i>410.9 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE <i>becoming acellular</i> DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>acute</i>
ANTECEDENT CAUSES		(B) <i>A known CV Disease</i> DUE TO, OR AS A CONSEQUENCE OF:		<i>yes</i>
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C)		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from <i>3-7</i> 1972 to <i>4-11</i> 1972 that (I) (we) last saw the deceased alive on <i>4-10</i> 1972 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <i>[Signature]</i>		23B. DATE SIGNED <i>4-11-72</i>		
23C. PHYSICIAN'S NAME (Type) <i>L. A. Kochman - M.D.</i>		23D. ADDRESS <i>7945 Sterenson Rd Balto 2nd 21208</i>		
24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE <i>14 Apr 72</i>	24C. NAME OF CEMETERY OR CREMATORY <i>Meadowridge</i>	24D. LOCATION (City, town, or county) <i>How 2nd Co Md</i>	(State)
25A. DATE REC'D BY HEALTH DEPT. <i>APR 13 1972</i>	25B. NAME OF REGISTRAR <i>John E. Suby, M.D.</i>	25C. FUNERAL DIRECTOR <i>Burgee Fongref Home</i> ADDRESS <i>15216 Md</i>		



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

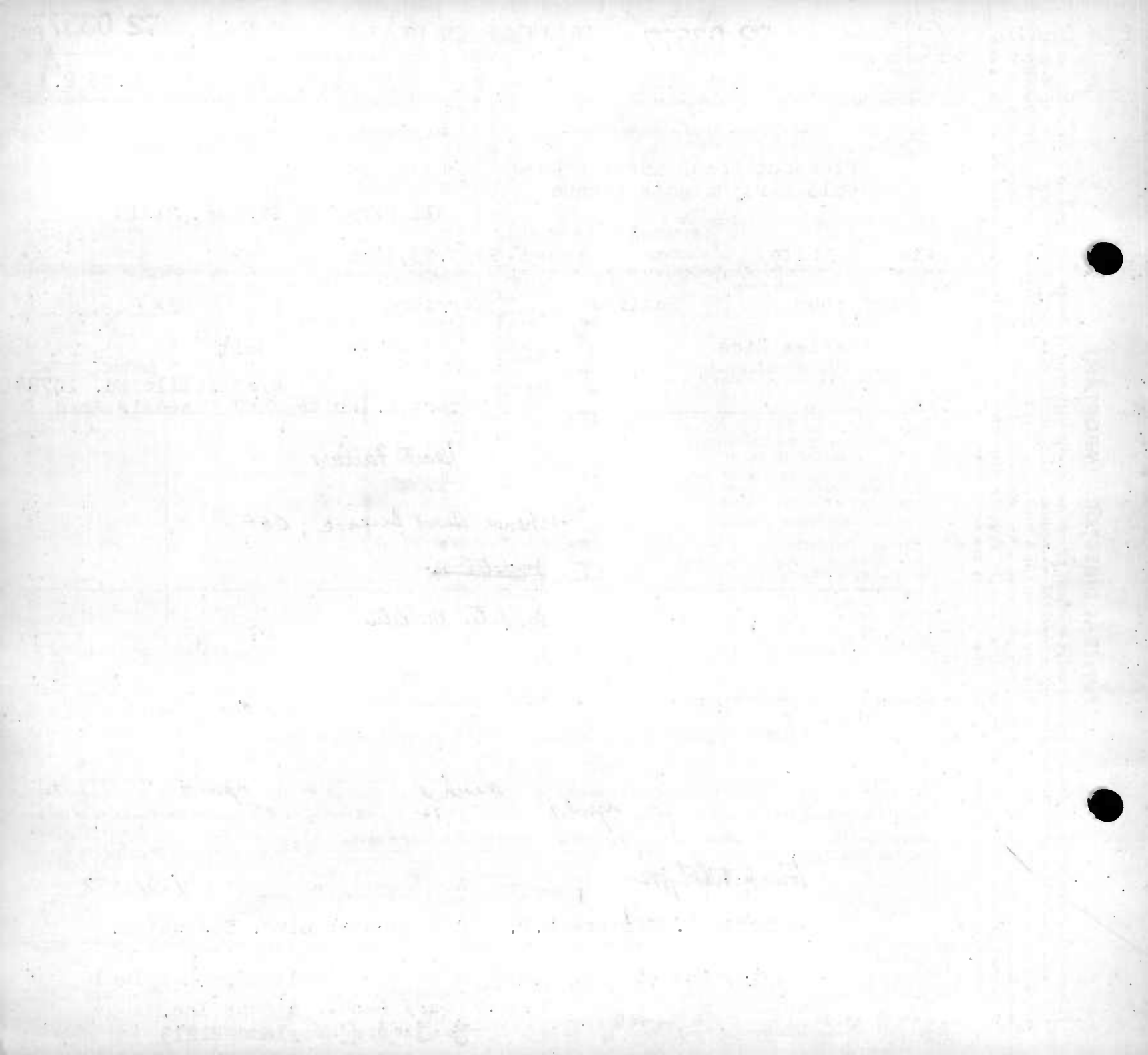
VS 150-REV. 1/1/68



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				CERTIFICATE OF DEATH		REG. NO. <u>72 03577</u>	
R-200 BIRTH NO.		72 03577					
1. NAME OF DECEASED (Type or Print) CHARLES RICE				2. DATE AND HOUR OF DEATH APRIL 7, 1972 9.05 P. M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 90 Pleasant Manor Nursing Home 4615 Park Heights Avenue				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 1206 C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 2511 Maryland Avenue 21218			
5. SEX Male	6. RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept. 25, 1889		9. AGE (In years last birthday) 82	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Lunch Room		10B. KIND OF BUSINESS OR INDUSTRY Retired		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Charles Rice				14. MOTHER'S MAIDEN NAME Sallie Smith			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS Hyattsville Md. 20794 Robert C. White 7847 Rosedale Road			
18. 412.3 14250.9 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Heart Failure ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Ischemic Heart Disease, CHF Diabetes No Diabetes Mellitus				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
19A. DATE OF OPERATION 0				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) no	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from March 3 19 72 to April 7 19 72 , that (I) (we) last saw the deceased alive on April 7 19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Humberto V. Certeza				23B. DATE SIGNED 4/10/1972		23C. PHYSICIAN'S NAME (Type) Humberto V. Certeza M.D.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial				24B. DATE 4/10/1972		24C. NAME OF CEMETERY or CREMATORY Western Cemetery	
25A. DATE REC'D BY HEALTH DEPT. APR 13 1972				25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR Henry Sander & Sons Inc.	
26A. ADDRESS Baltimore Maryland 21213				26B. ADDRESS Baltimore Maryland 21213			



72 03578 BALTIMORE CITY HEALTH DEPARTMENT
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

72 03578

BIRTH NO.

1. NAME OF DECEASED (Type or Print) HOWARD WARE		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour April 12, 1972 7:00 P.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 46 Lutheran Hospital		3. DATE PRONOUNCED DEAD Month Day Year Hour April 12, 1972 7:00 P.	
6. SEX Male		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
7. RACE Negro		C. CITY OR TOWN Baltimore	
9. DATE OF BIRTH 5-13-64		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
10. AGE (In years last birthday) 78		E. STREET AND NUMBER 3327 Edmondson Avenue	
11. BIRTHPLACE (State or foreign country) md. U.S.		12. CITIZEN OF WHAT COUNTRY?	
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		13. FATHER'S NAME Leon Ware	
14B. KIND OF BUSINESS OR INDUSTRY		15. MOTHER'S MAIDEN NAME Jakes	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO.	
18. INFORMANT		ADDRESS	

19. E81471 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		CAUSE OF DEATH (A) IMMEDIATE CAUSE Multiple injuries DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
---	--	---	--	--	--

20A. DATE OF OPERATION 4		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) No	
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Street		22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) Hilton St and Edmondson Avenue	
22D. TIME OF INJURY (APPROX.) Month (Day) (Year) (Hour) 4-12-72 5:15 P.		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? Pedestrian struck by auto	

23. I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE **Charles S. Springate** M.D.
EXAMINER'S NAME (Type) **Charles S. Springate, M.D.**

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED **April 13, 1972**

24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4-15-72		24C. NAME OF CEMETERY or CREMATORY Arbutus		24D. LOCATION (City, town, or county) (State) Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT. APR 14 1972		25B. NAME OF REGISTRAR Robert E. Taylor, Jr.		25C. FUNERAL DIRECTOR C. Wainwright		ADDRESS 2700 Edmondson Ave	

8080 55

8080 55

STANDARD FORM NO. 64

TO : [illegible]
FROM : [illegible]
SUBJECT : [illegible]
DATE : [illegible]
[illegible text follows]

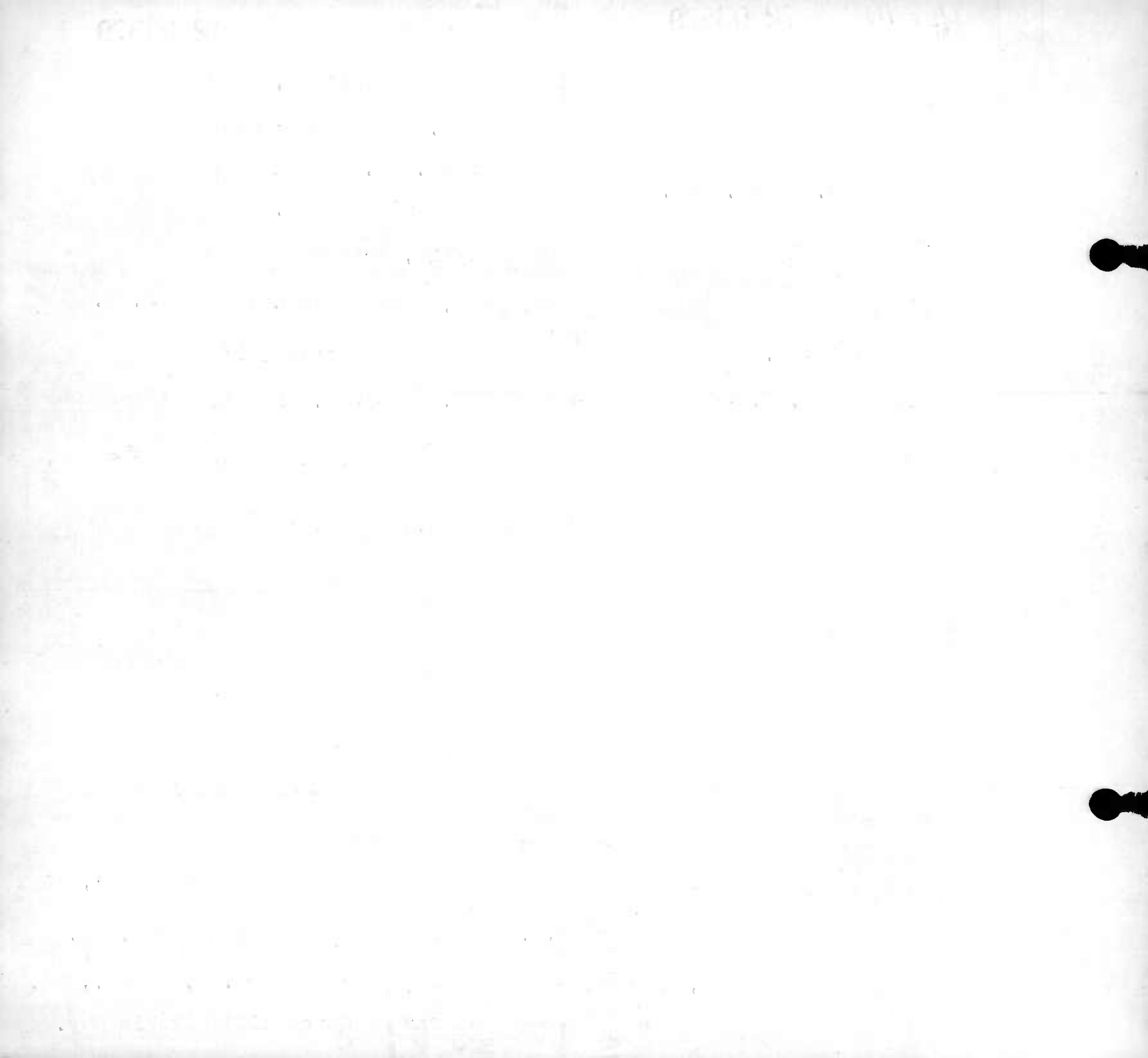
[illegible text follows]

[illegible text follows]

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

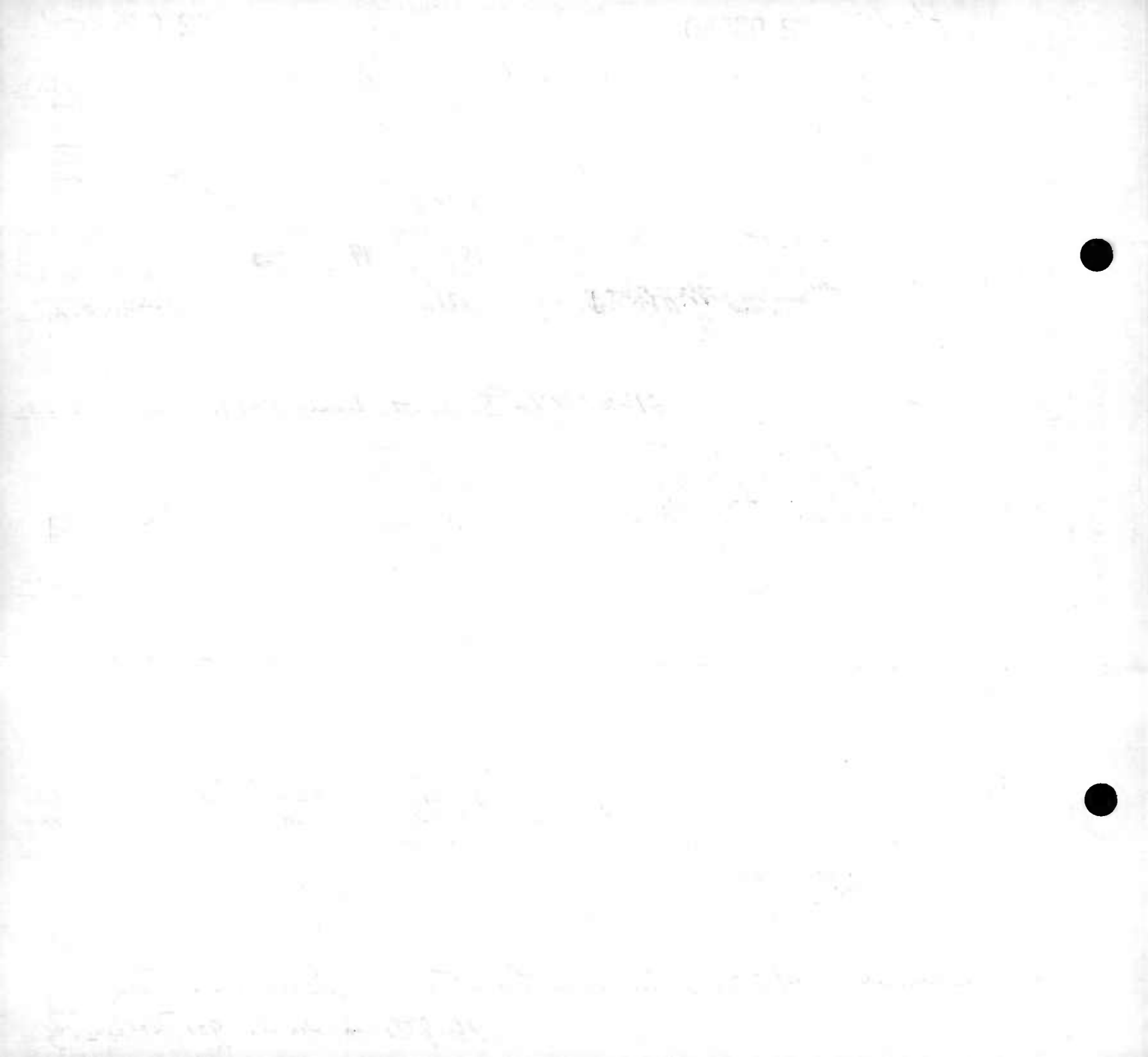
BALTIMORE CITY HEALTH DEPARTMENT											
P-540 72 03579					REG. NO. 72 03579						
BIRTH NO.					1. NAME OF DECEASED (Type or Print)						
					Robert Norman Pennell						
2. DATE AND HOUR OF DEATH					April 10, 1972						
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD					4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)						
FULL NAME OF HOSPITAL OR INSTITUTION					A. STATE B. COUNTY						
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)					Md. Anne Arundel 5200						
43 So. Balto. Gen. Hosp					C. CITY OR TOWN D. INSIDE CITY LIMITS?						
					Brook. Pk. YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
E. STREET AND NUMBER					125 Hilltop Rd.						
5. SEX		6. RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years lost birthday)			
Male		White		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		May 27, 1927		44			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10B. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country)			12. CITIZEN OF WHAT COUNTRY?		
Fireman			Balto City Fire Dept.			Pennsylvania			U. S.		
13. FATHER'S NAME					14. MOTHER'S MAIDEN NAME						
William S. Pennell					Weaverling						
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)					16. SOCIAL SECURITY NO.		17. INFORMANT			ADDRESS	
Yes W. W. 11					220 20 2160		Mrs. Velnia A. Pennell			1 Same	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH					CAUSE OF DEATH					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.)					Acute myocardial infarction					86 hours	
ANTECEDENT CAUSES					(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:						
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					(B) Atherosclerotic heart disease						
					(C)						
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).											
19A. DATE OF OPERATION			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			20A. AUTOPSY? (Yes or No)			20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
0						No					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from Jan 19 69 to 12-10/70, that (I) (we) last saw the deceased alive on Dec 10/70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.											
23A. SIGNATURE					23B. DATE SIGNED						
Lester Lebo M.D.					April 11, 1972						
23C. PHYSICIAN'S NAME (Type)					23D. ADDRESS						
Lester Lebo M.D.					Medical Arts Building Balto. Md.						
24A. BURIAL CREMATION, REMOVAL (Specify)			24B. DATE			24C. NAME of CEMETERY or CREMATORY			24D. LOCATION (City, town, or county) (State)		
Burial			April 13, 1972			Cedar Hill Cem.			Ritchie Hwy. A. A. Co., Md.		
25A. DATE REC'D BY HEALTH DEPT.			25B. NAME OF REGISTRAR			25C. FUNERAL DIRECTOR			ADDRESS		
APR 14 1972			George J. Gonce			4001 Ritchie Hwy.					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

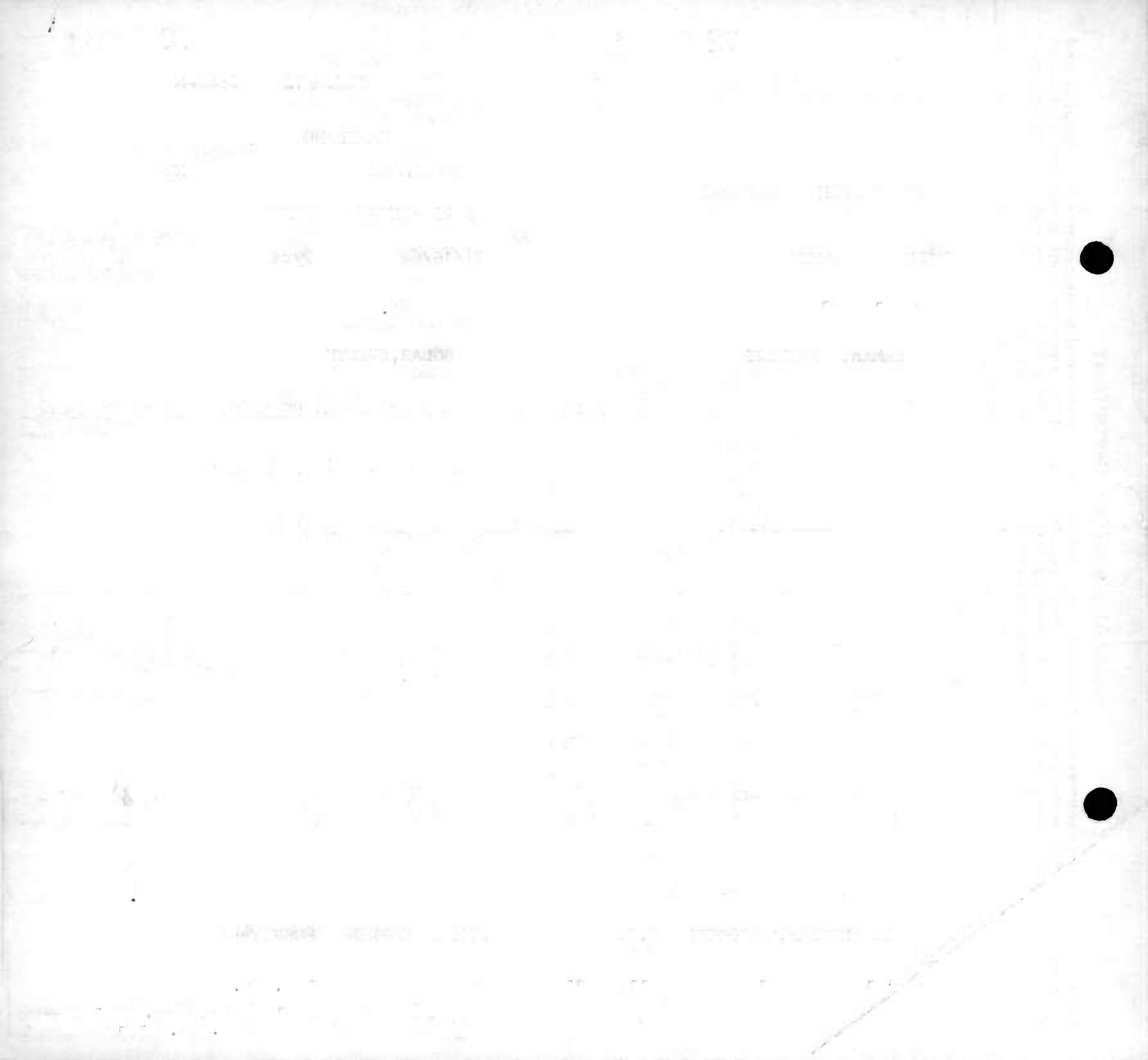
BIRTH NO. <u>H-400</u> <u>72 03580</u>		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. <u>72 03580</u>	
1. NAME OF DECEASED (Type or Print) <u>Holloway, Hillman P.</u>		2. DATE AND HOUR OF DEATH <u>4/12/1972</u> <u>4:15a M.</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>1201</u>			
FULL NAME OF HOSPITAL OR INSTITUTION <u>The Union Memorial Hospital</u> <u>4 Baltimore Maryland 21218</u>		C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <u>M</u>		6. RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <u>10/2/1899</u>		9. AGE (In years last birthday) <u>72</u> years		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Refrigerator Mender</u>	
11. BIRTHPLACE (State or foreign country) <u>Alabama</u>		12. CITIZEN OF WHAT COUNTRY? <u>American</u>		13. FATHER'S NAME <u>Hillman P. Holloway</u>	
14. MOTHER'S MAIDEN NAME <u>not known</u>		15. Was Deceased Ever In U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>21P-10-3836A</u>		16. SOCIAL SECURITY NO. <u>21P-10-3836A</u>	
17. INFORMANT <u>Dr. Dorothy Diddle</u>		ADDRESS <u>1241 W. Cross St. 21230</u>			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Sepsis</u> CERTIFICATION APPROVED BY <u>[Signature]</u> CHIEF MEDICAL EXAMINER		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Sepsis</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
(B) DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Third degree burns of chest, face and arms</u>		(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>4/5/72</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Third degree burns of face, arms and chest</u>		20A. AUTOPSY? (Yes or No) <u>NO</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <u>yes</u>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>Home</u>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <u>3706 N. Charles Street - 1201</u>	
21D. TIME OF INJURY (Approx.) <u>3 4/1972</u>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? <u>while thickening match front of flannel caught fire</u>	
22. I certify that (I) (this hospital) attended the deceased from <u>3/14/1972</u> to <u>4/12/1972</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>[Signature]</u>		23B. DATE SIGNED <u>4/12/1972</u>		23C. PHYSICIAN'S NAME (Type) <u>Y. K. SHETTY</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>burial</u>		24B. DATE <u>4/15/72</u>		24C. NAME OF CEMETERY or CREMATORY <u>Green Home Cemetery</u>	
24D. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>		25A. DATE REC'D BY HEALTH DEPT. <u>APR 14 1972</u>		25B. NAME OF REGISTRAR <u>[Signature]</u>	
25C. FUNERAL DIRECTOR <u>[Signature]</u>		ADDRESS <u>901 Hollins St. Balt. 21223</u>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 03581	
BIRTH NO. 1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH 04/08/72 5:45PM		3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD ZEMAN, PHILLIP CHARLES	
4. USUAL RESIDENCE (Where deceased lived, If institution; residence before admission) A. STATE B. COUNTY		5. CITY OR TOWN MARYLAND		6. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
7. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 3 JOHNS HOPKINS HOSPITAL		8. STREET AND NUMBER 3835 ELMORE AVENUE		9. AGE (In years last birthday) 9yrs	
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) School Child		11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME ZEMAN, PHILLIP		14. MOTHER'S MAIDEN NAME BOLAS, EVELYN		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no	
16. SOCIAL SECURITY NO. NONE		17. INFORMANT Raymond Zeman (father)		ADDRESS same as above	
18. CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) IMMEDIATE CAUSE <i>Cardio Respiratory Arrest</i> DUE TO, OR AS A CONSEQUENCE OF: (B) <i>Rhabdomyosarcoma of Pelvis</i> DUE TO, OR AS A CONSEQUENCE OF: (C) <i>Metastasis to Liver</i>		
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 4/3 1972 to 4/8 1972 that (I) (we) last saw the deceased alive on 4/8 1972 and that (my) (our) applan death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Catherine De Angelis</i>			23B. DATE SIGNED 4/8/72		23C. PHYSICIAN'S NAME (Type) DE ANGELIS, CATHERINE M.D.
24A. BURIAL CREMATION, REMOVAL (Specify) Burial			24B. DATE 4/12/72		24C. NAME of CEMETERY or CREMATORY Holly Hill Cemetery
24D. LOCATION (City, town, or county) (State) Balto. Md.			25A. DATE REC'D BY HEALTH DEPT. APR 14 1972		
25B. NAME OF REGISTRAR <i>[Signature]</i>			25C. FUNERAL DIRECTOR Schimunek Funeral Homes, Inc. 3331 Brehms Lane, Balto. Md. 21213		

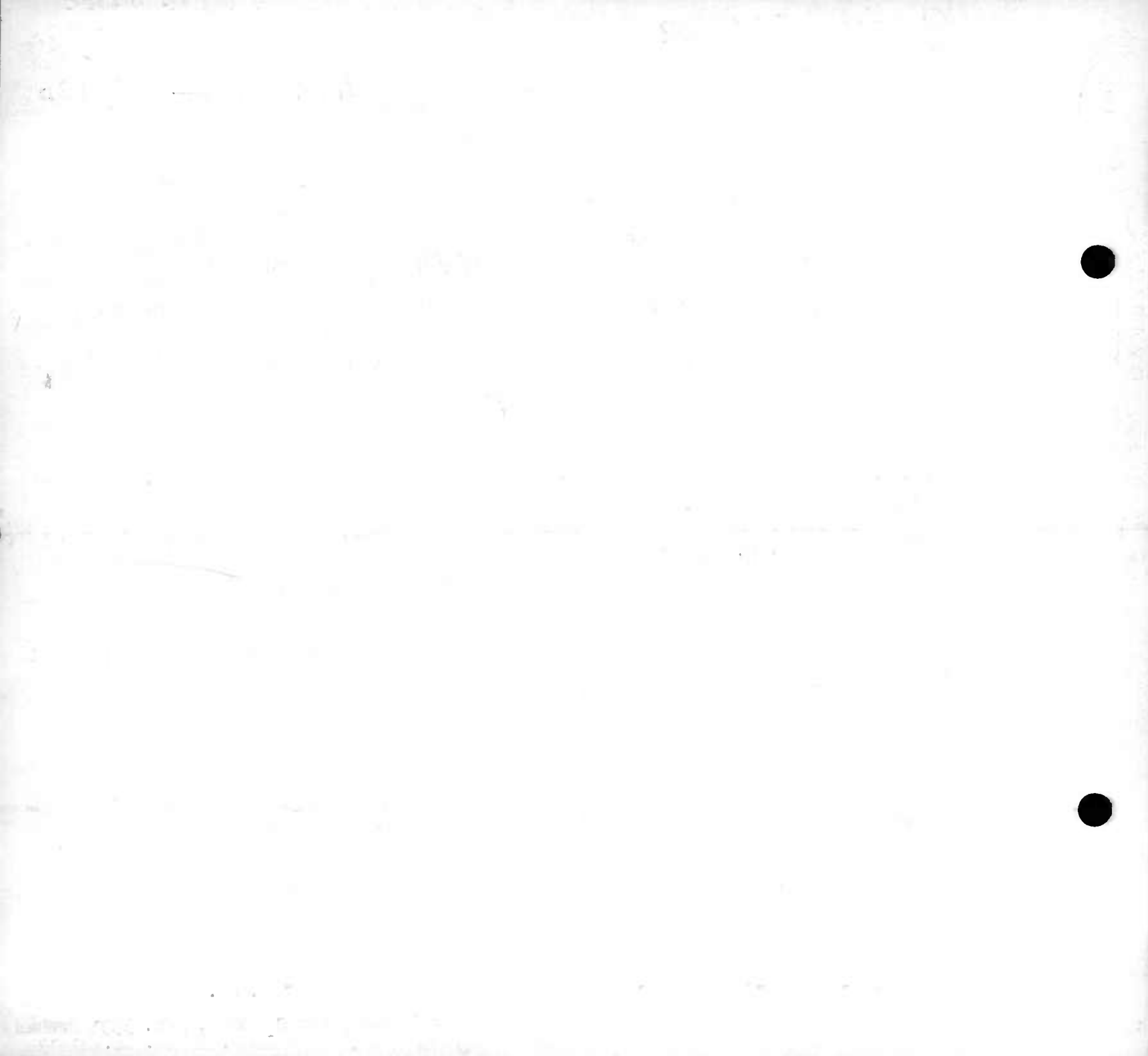


RELEASED BY MEDICAL INFORMATION

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

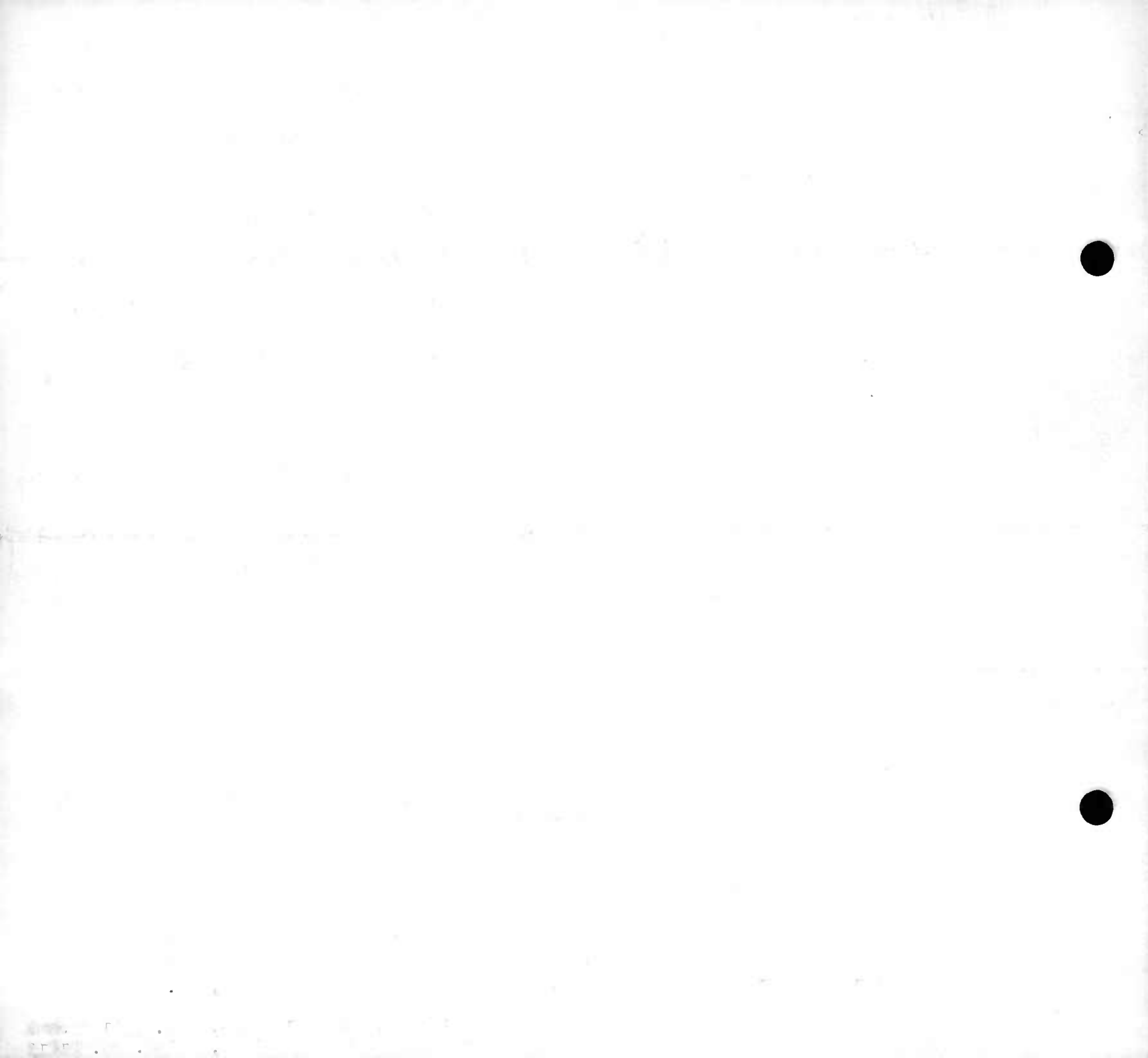
C-532 72 03582		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 3582	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) JAMES H. COUNTESS		2. DATE AND HOUR OF DEATH 4.9.72 1.13 PM	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD B. COUNTY 904		5. CITY OR TOWN BALTIMORE	
FULL NAME OF HOSPITAL OR INSTITUTION CHURCH HOME HOSPITAL		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX M		6. RACE A W		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH 6/5/07		9. AGE (In years last birthday) 64		10. If Under 1 Yr. Months Days 11. If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retd.		10B. KIND OF BUSINESS OR INDUSTRY Retd.		11. BIRTHPLACE (State or foreign country) MD	
12. CITIZEN OF WHAT COUNTRY? AMER.		13. FATHER'S NAME JAMES COUNTESS		14. MOTHER'S MAIDEN NAME MARGARET SCHINNING.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 213 07 7804		17. INFORMANT ADDRESS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, etc., but the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, EXAMINED, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). SEVERE ARTERIOSCLEROSIS. IMPENDING GANGRENE - 1 day.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: CARDIAC ARREST. (B) MYOCARDIAL INFARCTION DUE TO, OR AS A CONSEQUENCE OF: APPROX. 40 min. (C) HEMIBLOCKS, ATRIAL FIBRILLATION.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 33 min.	
19A. DATE OF OPERATION 4.9.72		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED IMPENDING GANGRENE OF BOTH LEGS.		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from 3.24. 1972 to 4.9. 1972 that (2) (we) last saw the deceased alive on 4.9. 1972 and that (3) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (4) (We) (did) (did not) view the body after death.					
23A. SIGNATURE V.S. SAILAM, M.D.		23B. DATE SIGNED 4.9.72		23C. PHYSICIAN'S NAME (Type) V.S. SAILAM, M.D.	
23D. ADDRESS CHURCH HOME HOSPITAL		23E. DEGREE		23F. DEGREE	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4/13/72		24C. NAME of CEMETERY or CREMATORY Holy Redeemer Cemetery	
24D. LOCATION Balto. Md.		24E. DATE REC'D BY HEALTH DEPT. APR 14 1972		24F. NAME OF REGISTRAR	
24G. FUNERAL DIRECTOR Schimunek Funeral Homes, Inc.		24H. ADDRESS 3331 Brehms Lane, Balto. Md. 21213		24I. 3577	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

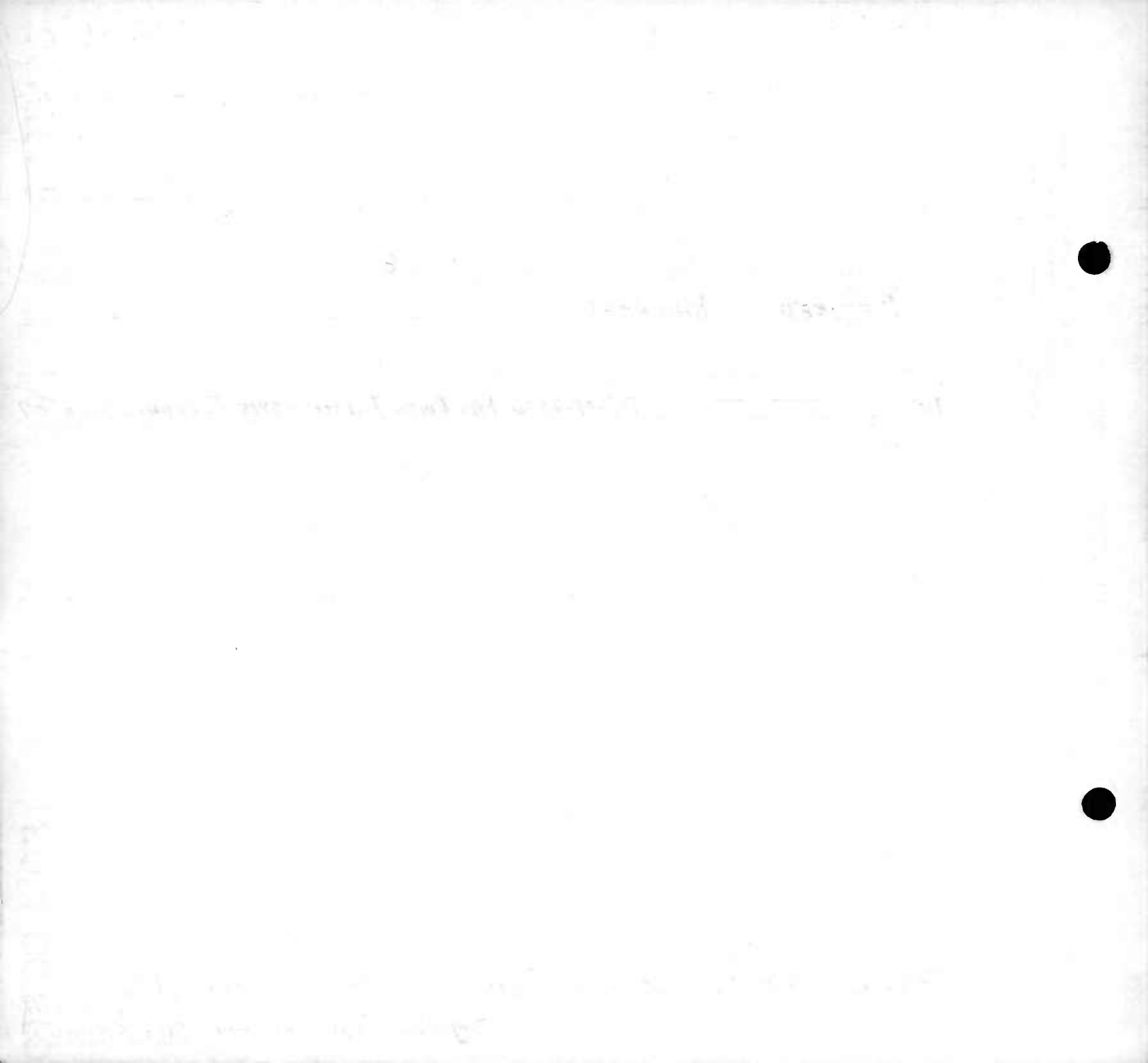
BIRTH NO. B-600		72 03583		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 03583	
1. NAME OF DECEASED (Type or Print) JOHN J. BAUER				2. DATE AND HOUR OF DEATH 4.8.72 10.30 P M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 35 CHORCH HOME & HOSPITAL				4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE STATE of Maryland 2632 C. CITY OR TOWN CITY. D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 4753 HOMESDALE AVE.			
5. SEX M	6. RACE W.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 03/02/1900	9. AGE (In years last birthday) 72	If Under 1 Yr. Months Days If Under 24 Hrs. Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unknown		10B. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME ADAM BAUER.				14. MOTHER'S MAIDEN NAME ROSE BECKMAN			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 717-07-7287		17. INFORMANT Hospital Cart		ADDRESS	
18. 679-31 CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 19A. DATE OF OPERATION 0 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 20A. AUTOPSY? (Yes or No) 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> 21F. HOW DID INJURY OCCUR? 22. I certify that (I) (this hospital) attended the deceased from 4.2.72 19 to 4.8.1972 that (I) (we) last saw the deceased alive on 4.8.1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. 23A. SIGNATURE Satpal Singh DEGREE M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> 23B. DATE SIGNED 4.8.72 23C. PHYSICIAN'S NAME (Type) SATPAL SINGH M.D. 23D. ADDRESS Church Home & Hospital. 24A. BURIAL CREMATION, REMOVAL (Specify) Burial 24B. DATE 4/12/72 24C. NAME of CEMETERY or CREMATORY Oak Lawn Cemetery 24D. LOCATION (City, town, or county) (State) Baltimore, Md. 25A. DATE REC'D BY HEALTH DEPT. APR 14 1972 25B. NAME OF REGISTRAR Robert E. Huber, M.D. 25C. FUNERAL DIRECTOR Schimunek Funeral Homes, Inc. ADDRESS 3331 Brehms Lane, Balto., Md. 21213							



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Baltimore City Health Department				REG. NO. <u>72 03584</u>	
BIRTH NO. <u>M-620</u>		72 03584		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <u>LAWRENCE R. MURK</u>			2. DATE AND HOUR OF DEATH <u>APRIL 11, '72 11:45 P.M.</u>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>1348</u>		
FULL NAME OF HOSPITAL OR INSTITUTION <u>44 UNION MEMORIAL HOSPITAL</u>			C. CITY OR TOWN <u>BALTIMORE</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			E. STREET AND NUMBER <u>3845 QUARRY AVENUE</u>		
5. SEX <u>M</u>	6. RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-09-1883</u>	9. AGE (In years last birthday) <u>88</u>	10. Under 1 Yr. Months Days If Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>RAILROAD</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
13. FATHER'S NAME <u>JOHN MURK</u>			14. MOTHER'S MAIDEN NAME <u>MARY BLOOM</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>717-07-8336</u>		17. INFORMANT <u>MRS EDITH FULTON - 3715 FERNDALE AVE 07</u>	
18. <u>5-35-X1</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>SHOCK + UREMIA</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>GASTROINTESTINAL BLEEDING</u> DUE TO, OR AS A CONSEQUENCE OF: (C) <u>GASTRITIS + ARTERIO-SCLEROSIS</u>		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>03/18</u> 19 <u>72</u> to <u>04/11</u> 19 <u>72</u> that (I) (we) last saw the deceased alive on <u>04/11</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>C. E. U. M. A.</u>			23B. DATE SIGNED <u>04/11/72</u>		23C. PHYSICIAN'S NAME (Type) <u>CESSAR ULLMAN</u>
23D. ADDRESS <u>33rd and Calvert St</u>			23E. DEGREE <u>INTERN</u>		
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>	24B. DATE <u>4/15/72</u>	24C. NAME of CEMETERY or CREMATORY <u>WOODLAWN CEM.</u>		24D. LOCATION (City, town, or county) (State) <u>BALTIMORE, MD.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>APR 14 1972</u>		25B. NAME OF REGISTRAR <u>Robert E. Sauer</u>		25C. FUNERAL DIRECTOR <u>DONALD H. FANERL</u>	
ADDRESS <u>2121 3818 ROLAND AVE</u>					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Baltimore City Health Department				CERTIFICATE OF DEATH		REG. NO. <u>72 03585</u>	
BIRTH NO. 1. NAME OF DECEASED (Type or Print) <u>LOEWENSTIEN, Perry H.</u>				2. DATE AND HOUR OF DEATH <u>April 9, 1972</u> <u>7:05 P</u> <u>M.</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>23 Veterans Administration Hospital</u> <u>3900 Loch Raven Boulevard</u> <u>Baltimore, Maryland 21218</u>				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore</u> C. CITY OR TOWN <u>Chase</u> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER <u>Box 448 1/2 University Dr.</u>			
5. SEX <u>Male</u>	6. RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>3/12/93</u>	9. AGE (In years last birthday) <u>79</u>	If Under 1 Yr. Months: <u> </u> Days: <u> </u>	If Under 24 Hrs. Hours: <u> </u> Min: <u> </u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CARPENTER</u>				10B. KIND OF BUSINESS OR INDUSTRY <u>RETIRED</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>				13. FATHER'S NAME <u>Charles Loewenstien</u>			
14. MOTHER'S MAIDEN NAME <u>Elizabeth Brendel</u>				15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>Yes</u> <u>7/20/18 - 1/24/19</u>			
16. SOCIAL SECURITY NO. <u>214-40-4640</u>				17. INFORMANT <u>VA Hospital Records</u> <u>3900 Loch Raven Blvd., Balto., Md</u>			
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. I II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				(A) IMMEDIATE CAUSE <u>Lung abscess</u> DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 months</u> <u>7 years</u>	
19A. DATE OF OPERATION <u> </u>				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u> </u>		20A. AUTOPSY? (Yes or No) <u>NO</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u> </u>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <u> </u>	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) <u> </u>				21E. INJURY OCCURRED While At <input type="checkbox"/> Nat While <input type="checkbox"/> Work At Work		21F. HOW DID INJURY OCCUR? <u> </u>	
22. I certify that (1) (this hospital) attended the deceased from <u>February 26th</u> <u>19 72</u> to <u>April 9th</u> <u>19 72</u>, that (1) (we) last saw the deceased alive on <u>April 9th</u> <u>19 72</u> and that in (1) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (not) view the body after death.							
23A. SIGNATURE <u>James A. Quinlan, Jr.</u>				23B. DATE SIGNED <u>4/10/72</u>		23C. PHYSICIAN'S NAME (Type) <u>JAMES A. QUINLAN, JR., M.D.</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>				24B. DATE <u>4-13-72</u>		24C. NAME OF CEMETERY or CREMATORY <u>Loudon Park Cemetery</u>	
24D. LOCATION (City, town, or county) <u>Baltimore, Maryland</u>				24E. DATE REC'D BY HEALTH DEPT. <u>APR 14 1972</u>			
25A. NAME OF REGISTRAR <u>Robert E. Taylor</u>				25B. FUNERAL DIRECTOR <u>John C. Miller Inc.</u>		25C. ADDRESS <u>6415 Belair Road-21206</u>	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Baltimore City Health Department				REG. NO. 72 03586	
M-230 BIRTH NO. 72 03586		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) MAGGID, JOHN B.			2. DATE AND HOUR OF DEATH April 12, 1972 3:10 P.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) SOUTH BALTIMORE GENERAL HOSPITAL 43			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY 2831 C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 6512 Eberle Dr. APT 203		
5. SEX MALE	6. RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH XXXXXX	9. AGE (In years lost birthday) 86	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) XXXXXXXXXX MANUFACTURING		10B. KIND OF BUSINESS OR INDUSTRY FURNITURE		11. BIRTHPLACE (State or foreign country) XXXXXXXXXX RUSSIA	
12. CITIZEN OF WHAT COUNTRY? XXXXXXXXXX U.S.A.		13. FATHER'S NAME XXXXXXXXXX JACOB MAGGID		14. MOTHER'S MAIDEN NAME XXXXXXXXXX DEVORAH ?	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 216-09-0602-A		17. INFORMANT ADDRESS	
18. 412.4 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: cardiac standstill 2° to metabolic & electrolyte imbalance + atrial fibrillation (B) acute chronic congestive heart failure DUE TO, OR AS A CONSEQUENCE OF: (C) arteriosclerotic cardiovascular disease chronic insufficiency, lower extremities sudden ulcer; diabetes mellitus, mild			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I. (A).					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from March 29 1972 to April 12 1972 , that (I) (we) last saw the deceased alive on April 12 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Nora B. Licalde-de Lara H.D. OEGREE				23B. DATE SIGNED 4-12-72	
23C. PHYSICIAN'S NAME (Type) NORA L. DE LARA OEGREE				23D. ADDRESS SOUTH BALTO. GEN. HOSPITAL	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 4-13-72		24C. NAME OF CEMETERY or CREMATORY ANSHE EMUNAH	
24D. LOCATION (City, town, or county) (State) BALTIMORE, MARYLAND		25A. DATE REC'D BY HEALTH DEPT. APR 14 1972			
25B. NAME OF REGISTRAR John E. [Signature]		25C. FUNERAL DIRECTOR ADDRESS SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD			

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 03587	
0-163		72 03587		CERTIFICATE OF DEATH	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		OVERTON, JESSIE JR.		April 13, 1972 5:55 A M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE B. COUNTY			
23 Veterans Administration Hospital 3900 Loch Raven Boulevard Baltimore, Maryland 21218		Maryland C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER			
		924 Watson Street			
5. SEX	6. RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. If Under 1 Yr. Months Days
Male	Negro	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	4/12/17	55	11. If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
truck driver				Pasquetank Co., N.C.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
Jessie Overton		Daisey Williams		USA	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
Yes 7/12/43 - 11/29/45		237-03-0090		VA Hospital Records 3900 Loch Raven Blvd., Balto., Md 21218	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		1-1 1/2 Weeks	
ANTECEDENT CAUSES		(B) DUE TO, OR AS A CONSEQUENCE OF:		3 Years	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) DUE TO, OR AS A CONSEQUENCE OF:			
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
				NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from March 26th 19 72 to April 13th 19 72, that (I) (we) last saw the deceased alive on April 13th 19 72 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
William A. Stuart M.D.				4/13/72	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
William A. Stuart, M. D.		3900 Loch Raven Boulevard Baltimore, Maryland 21218			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		4/16/72		New Oak Grove Cemetery	
24D. LOCATION (City, town, or county) (State)		24E. DATE REC'D BY HEALTH DEPT.		24F. NAME OF REGISTRAR	
Elizabeth City, North Carolina		APR 14 1972		Robert E. Johnson	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
				William E. Johnson 8521 Loch Raven Blvd.	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
BIRTH NO. A-553 72 03588					CERTIFICATE OF DEATH X REG. NO. 72 03588				
1. NAME OF DECEASED (Type or Print) MARTHA E. AMENDT					2. DATE AND HOUR OF DEATH 4.12.72 5.10A M.				
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Church Home & Hospital 35					4. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) A. STATE BALTO B. COUNTY Parkville County 5300 C. CITY OR TOWN County D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER 2916 Hillcrest Ave.				
5. SEX F	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-9-83	9. AGE (In years last birthday) 88	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unemployed			10B. KIND OF BUSINESS OR INDUSTRY —			11. BIRTHPLACE (State or foreign country) MD.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Thomas Whittle			14. MOTHER'S MAIDEN NAME Unknown			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO			
16. SOCIAL SECURITY NO. 212-50-6852			17. INFORMANT Mrs. Rosalie E. Hellman			ADDRESS Same as Above			
18. 242.21 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Antecedent Causes DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Unknown (B) Acute Myocardial Infarction (C) Hyperthyroid Heart disease APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 days.				
19A. DATE OF OPERATION 4.9.72		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from 4.9.1972 to 4.12.1972 that (I) (we) last saw the deceased alive on 4.12.1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE Satpal Singh M.D.				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 4.12.72			
23C. PHYSICIAN'S NAME (Type) SATPAL SINGH M.D.				23D. ADDRESS Church Home & Hospital.					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4/15/72		24C. NAME OF CEMETERY OR CREMATORY Baltimore		24D. LOCATION (City, town, or county) (State) Baltimore, Md.			
25A. DATE REC'D BY HEALTH DEPT. APR 14 1972		25B. NAME OF REGISTRAR 227.3 000		25C. FUNERAL DIRECTOR Leonard B. Ruck, Inc.		ADDRESS Balto., Md.			

Thompson
Thompson

1941-1942
1941-1942

1941-1942

1941-1942

1941-1942

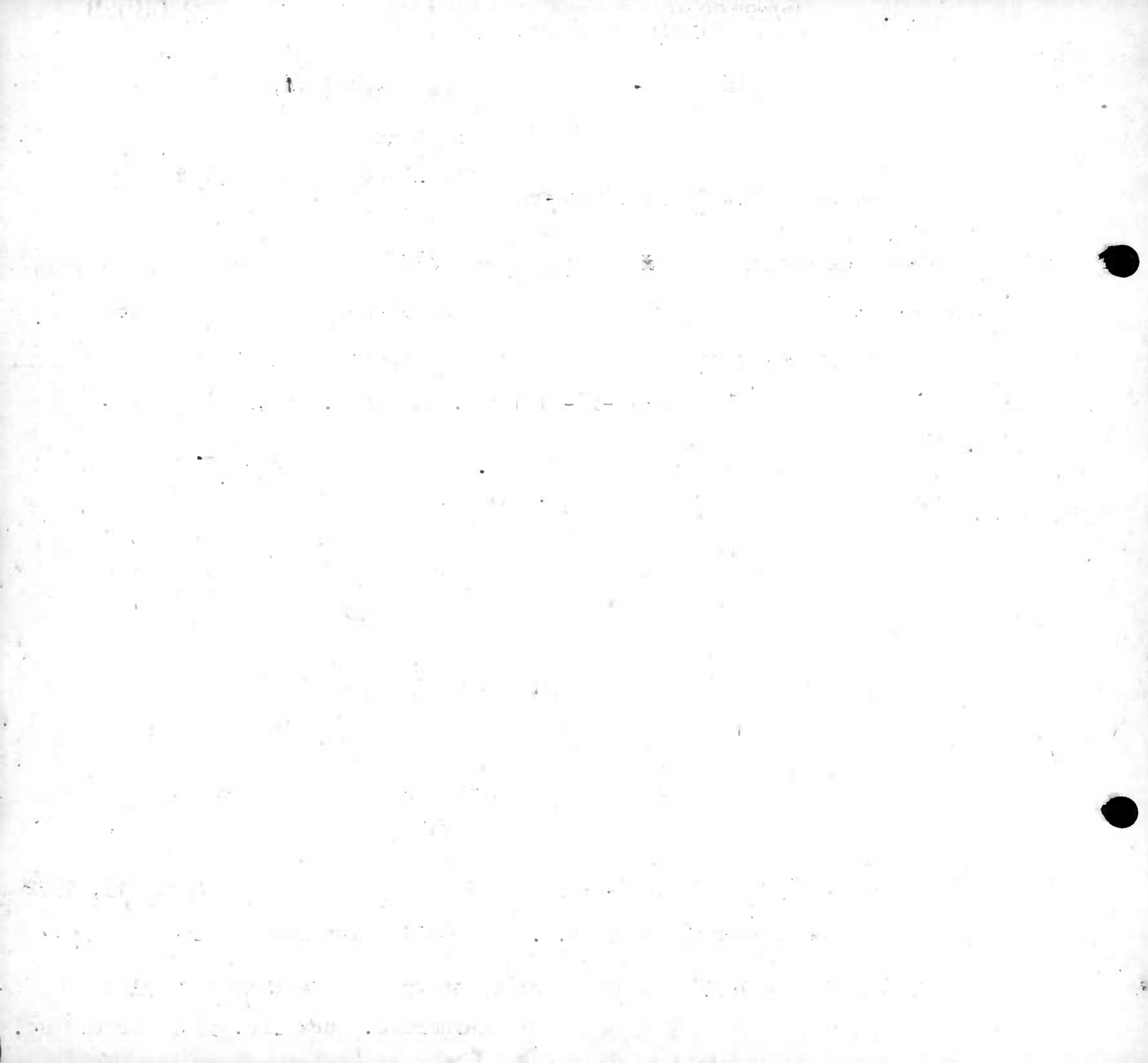
1941-1942

1941-1942

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Baltimore City Health Department				72 03589
72 03589				REG. NO. 11
BIRTH NO.		1. NAME OF DECEASED (Type or Print) Sophia Beale		
2. DATE AND HOUR OF DEATH April 10, 1972 11⁰⁰ P. M.		3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore		5. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital or institution, give street address or location) 90 House in the Pines Belvedere		
6. DATE OF BIRTH 2/29/1884		7. AGE (In years lost birthday) 88		
8. SEX Female		9. RACE Caucasian		
10. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		11. BIRTHPLACE (State or foreign country) Maryland		
12. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		13. KIND OF BUSINESS OR INDUSTRY		
14. FATHER'S NAME Ernst Domschke		15. MOTHER'S MAIDEN NAME Wilhelmina Hartung		
16. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		17. SOCIAL SECURITY NO. 218-54-4111		
18. INFORMANT Mrs. Emelia B. Strott		ADDRESS Same		
19. CAUSE OF DEATH I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 yr. 10 yr. 5 yr. 2 yr.		
20. DATE OF OPERATION		21. CONDITION FOR WHICH OPERATION WAS PERFORMED		
22. A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		23. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		
24. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		25. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		
26. I certify that (I) (this hospital) attended the deceased from Jan 28 1971 to April 10 1972 , that (I) (we) last saw the deceased alive on April 7 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.		27. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
28. SIGNATURE Lester Coleman M.D.		29. DATE SIGNED April 13, 1972		
30. PHYSICIAN'S NAME (Type) Lester Coleman M.D.		31. ADDRESS 6821 Reisterstown Road		
32. BURIAL CREMATION, REMOVAL (Specify) Burial		33. DATE 4/14/72		
34. NAME OF CEMETERY or CREMATORY Loudon Park Cemetery		35. LOCATION (City, town, or county) (State) Baltimore Maryland		
36. DATE REC'D BY HEALTH DEPT. APR 14 1972		37. NAME OF REGISTRAR Robert E. Fisher M.D.		
38. FUNERAL DIRECTOR Leonard J. Ruck Inc.		ADDRESS 5305 Harford Rd.		



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				72 03590		REG. NO. 72 03590	
BIRTH NO. <u>H-652</u>		1. NAME OF DECEASED (Type or Print) <u>HARRINGTON JOHN</u>		2. DATE AND HOUR OF DEATH <u>4-11-1972</u> <u>7:01 A.M.</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)		A. STATE <u>Texas</u>		B. COUNTY <u>V40</u>	
FULL NAME OF HOSPITAL OR INSTITUTION <u>44</u> <u>Unim Memorial Hospital</u>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN <u>Dallas</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <u>M</u>		6. RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <u>1-31-1909</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		9. AGE (in years last birthday) <u>63</u>		If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
11. BIRTHPLACE (State or foreign country) <u>Mississippi</u>		12. CITIZEN OF WHAT COUNTRY? <u>AMERICAN</u>		13. FATHER'S NAME <u>James Harrington</u>		14. MOTHER'S MAIDEN NAME <u>Blanche ?</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Mrs. Susann Block</u>		ADDRESS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>15570 I</u> <u>Hepatitis - Hepatic Coma</u>		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Liver cirrhosis -</u> (B) DUE TO, OR AS A CONSEQUENCE OF: <u>GI bleeding, severe</u> (C) <u>GI bleeding, severe</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>3-16</u> 19 <u>72</u> to <u>4-11</u> 19 <u>72</u> that (I) (we) last saw the deceased alive on <u>4-11</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.		23A. SIGNATURE <u>[Signature]</u> <u>H.D. DEGREE</u>		23B. DATE SIGNED <u>4-11-1972</u>		23C. PHYSICIAN'S NAME (Type) <u>G. Heston</u> <u>Nahod</u> <u>DEGREE</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>4/15/72</u>		24C. NAME of CEMETERY or CREMATORY <u>Grove Hill Cemetery</u>		24D. LOCATION (City, town, or county) (State) <u>Dallas Texas</u>	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR <u>Leonard J. Ruck Inc. 5305 Harford Rd. 21214</u>		ADDRESS	

THE NEW YORK PUBLIC LIBRARY

ASTOR LENOX TILDEN FOUNDATION

500 5TH AVENUE NEW YORK 17, N.Y.

1911

1911

1911

1911

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

<p>P-240 72 03591 BALTIMORE CITY HEALTH DEPARTMENT</p> <p style="text-align: center;">CERTIFICATE OF DEATH</p>		<p>REG. NO. 72 03591</p>	
<p>BIRTH NO.</p> <p>1. NAME OF DECEASED (Type or Print) Mary E. Pascal</p>		<p>2. DATE AND HOUR OF DEATH April 11, 1972 4:30 P.M.</p>	
<p>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</p> <p>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 90 Greenwood Acres Nursing Home</p>		<p>4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY 301</p> <p>C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></p> <p>E. STREET AND NUMBER 310 So. Spring Court</p>	
<p>5. SEX Female</p>	<p>6. RACE Caucasian</p>	<p>7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/></p>	<p>8. DATE OF BIRTH May 1884</p> <p>9. AGE (In years last birthday) 88 87</p> <p>10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife</p>
<p>10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife</p>		<p>10B. KIND OF BUSINESS OR INDUSTRY XXXXX</p>	
<p>11. BIRTHPLACE (State or foreign country) Maryland</p>		<p>12. CITIZEN OF WHAT COUNTRY? U.S.A.</p>	
<p>13. FATHER'S NAME Charles E. Pascal</p>		<p>14. MOTHER'S MAIDEN NAME Katherine Volland</p>	
<p>15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No</p>		<p>16. SOCIAL SECURITY NO. 214-56-9935</p>	
<p>17. INFORMANT Mrs. Mary E. Roden</p>		<p>ADDRESS 1624 Joplin Street</p>	
<p>18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Diabetes Mellitus</p>		<p>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 Yrs.</p>	
<p>19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p>		<p>(A) IMMEDIATE CAUSE Diabetes Mellitus DUE TO, OR AS A CONSEQUENCE OF:</p> <p>(B) DUE TO, OR AS A CONSEQUENCE OF:</p> <p>(C) DUE TO, OR AS A CONSEQUENCE OF:</p>	
<p>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).</p>			
<p>19A. DATE OF OPERATION 0</p>		<p>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</p>	
<p>20A. AUTOPSY? (Yes or No) No</p>		<p>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</p>	
<p>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/></p>		<p>21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)</p>	
<p>21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)</p>		<p>21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)</p>	
<p>21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/></p>		<p>21F. HOW DID INJURY OCCUR?</p>	
<p>22. I certify that (I) (this hospital) attended the deceased from Sept 1971 to April 1972 that (I) (we) last saw the deceased alive on April 6 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</p>			
<p>23A. SIGNATURE Stanley Z. Felzenberg, M.D.</p>		<p>23B. DATE SIGNED 4/11/72</p>	
<p>23C. PHYSICIAN'S NAME (Type) Stanley Z. Felzenberg, M.D.</p>		<p>23D. ADDRESS 222 St. Paul Street</p>	
<p>24A. BURIAL CREMATION, REMOVAL (Specify) Burial</p>		<p>24B. DATE 4/13/72</p>	
<p>24C. NAME OF CEMETERY OR CREMATORY Oak Lawn Cemetery</p>		<p>24D. LOCATION (City, town, or county) (State) Baltimore, Maryland</p>	
<p>25A. DATE REC'D BY HEALTH DEPT. APR 14 1972</p>		<p>25B. NAME OF REGISTRAR Robert E. ...</p>	
<p>25C. FUNERAL DIRECTOR John A. ...</p>		<p>ADDRESS 3000 E. Baltimore St.</p>	

3706 Victoria R

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. <u>72 03592</u>
BIRTH NO. <u>M-200</u>				
1. NAME OF DECEASED (Type or Print) <u>AUGUST HOWARD HARRY MACK.</u>		2. DATE AND HOUR OF DEATH <u>April 12, 1972.</u> <u>3:30 P.M.</u>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <u>00</u>		A. STATE <u>Md.</u> B. COUNTY <u>2609</u>		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>3827 Fait Ave.</u> <u>Balto., 21224, Md.</u>		C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
		E. STREET AND NUMBER <u>3827 Fait Ave. # 21224.</u>		
5. SEX <u>Male</u>	6. RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 1, 1915</u>	9. AGE (In years last birthday) <u>56</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Gardener</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Nat. Brewing Co.</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				
13. FATHER'S NAME <u>HARRY MACK</u>		14. MOTHER'S MAIDEN NAME <u>ANNA M. WINKELMAN</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>213-03-1613</u>		17. INFORMANT <u>Margaret A. Mack</u>
				ADDRESS <u>Same.</u>
18. <u>199.1</u> I <u>I</u> CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) <u>Terminal Cancer</u>				<u>6 Months</u>
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from <u>3/15/72</u> 19 <u>72</u> to <u>April 12</u> 19 <u>72</u> , that (I) (we) last saw the deceased alive on <u>April 12</u> , 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <u>Artemio Arciaga Jr.</u>				23B. DATE SIGNED <u>4/14/72</u>
23C. PHYSICIAN'S NAME (Type) <u>ARTEMIO ARCIAGA, JR.</u>		23D. ADDRESS <u>3501 Fait Ave., Balto., 21224, Md.</u>		
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>4-15-72</u>	24C. NAME OF CEMETERY or CREMATORY <u>Sacred Heart Cem.</u>	
24D. LOCATION (City, town, or county) (State) <u>7401 German Hill Rd., Ba. Co., Md.</u>				
25A. DATE REC'D BY HEALTH DEPT. <u>APR 14 1972</u>		25B. NAME OF REGISTRAR <u>Charles J. Sepler</u>		25C. FUNERAL DIRECTOR <u>701 S. Conkling St. Balto., 21224, Md.</u>

SECRET

SECRET

SECRET

SECRET

SECRET

SECRET

SECRET

SECRET

SECRET

SECRET

SECRET

SECRET

SECRET

SECRET

SECRET

SECRET

SECRET

SECRET

SECRET

SECRET

SECRET

SECRET

SECRET

SECRET

SECRET

SECRET

SECRET

SECRET

SECRET

SECRET

SECRET

SECRET

SECRET

SECRET

SECRET

SECRET

SECRET

SECRET

SECRET

SECRET

SECRET

SECRET

SECRET

SECRET

SECRET

SECRET

SECRET

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

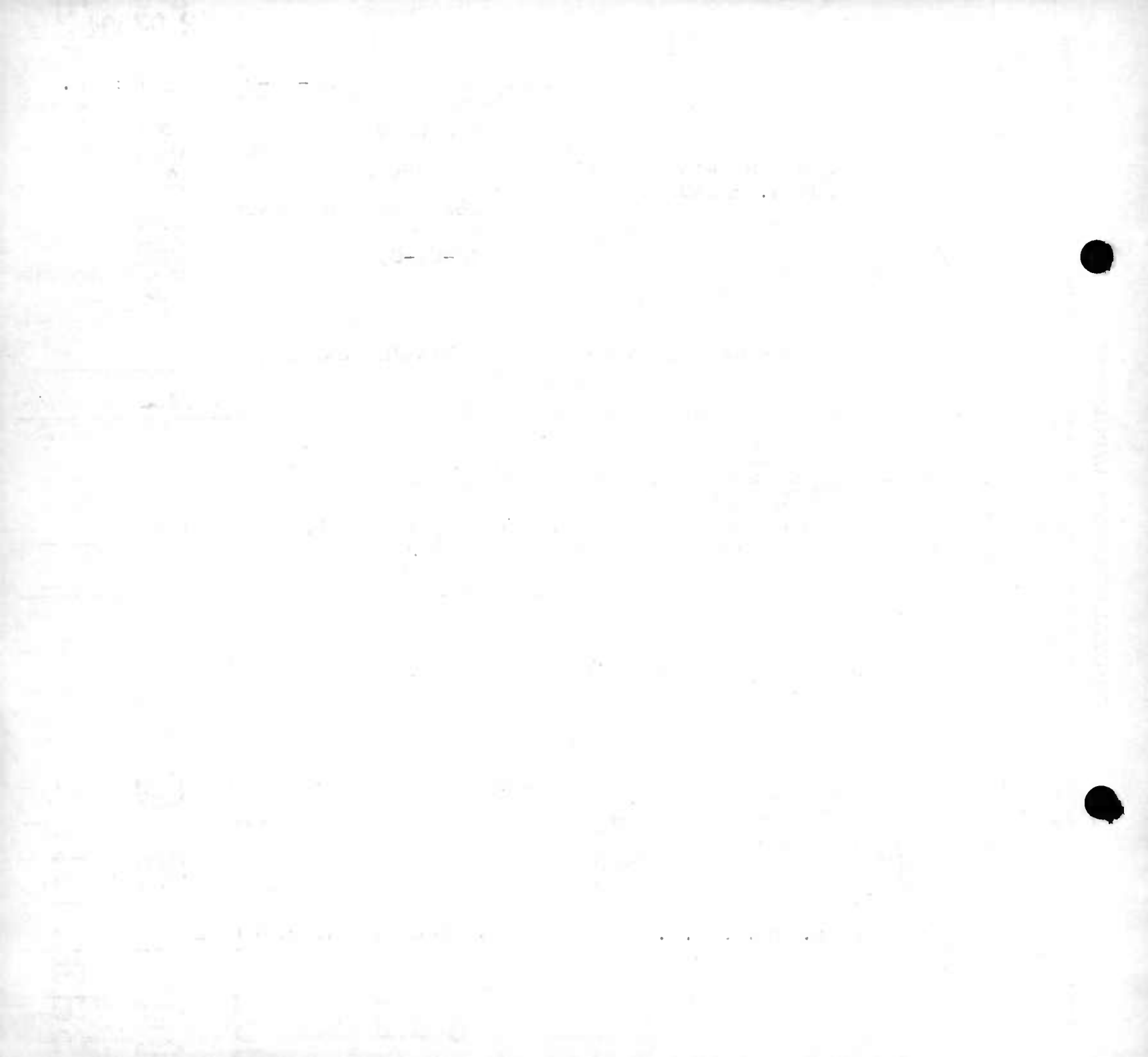
Baltimore City Health Department				REG. NO. <u>72 03593</u>	
G-431 72 03593		CERTIFICATE OF DEATH			
BIRTH NO. <u>1</u>		1. NAME OF DECEASED (Type or Print) <u>MR. GUSTAVE GELDOF</u>			
2. DATE AND HOUR OF DEATH <u>4-10-72</u>		M. <u>11:30 P</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>CHURCH HOME & HOSPITAL</u>		A. STATE <u>MARYLAND</u>		B. COUNTY <u>302</u>	
C. CITY OR TOWN <u>BALTIMORE</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
E. STREET AND NUMBER <u>46 S. ALBERMARLE # 2</u>					
5. SEX <u>M</u>	6. RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-27-85</u>	9. AGE (In years last birthday) <u>86</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>SEAMAN</u>		11. BIRTHPLACE (State or foreign country) <u>BELGIUM</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>UNKNOWN</u>		14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>219 03 3999A</u>		17. INFORMANT <u>Ms. Louise Cissel - 368 Main St. - Laurel, Md. 20810</u>	
18. <u>046X1</u>		CAUSE OF DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		(A) IMMEDIATE CAUSE <u>MENINGOENCEPHALITIS</u>			
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		DUE TO, OR AS A CONSEQUENCE OF:			
ANTECEDENT CAUSES		(B) <u>INFECTION; (BACTERIAL)</u>			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		DUE TO, OR AS A CONSEQUENCE OF:			
		(C) <u>PROLONGED</u>			
II		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>4-10</u> 19 <u>72</u> to <u>4-10</u> 19 <u>72</u> that (I) (we) lost saw the deceased alive on <u>4/10</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>MA. ELNA V. MARGAY</u> M.D. DEGREE		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>4-10-72</u>	
23C. PHYSICIAN'S NAME (Type) <u>MA. ELNA V. MARGAY</u> M.D. DEGREE		23D. ADDRESS <u>100 N BROADWAY BALTIMORE, MARYLAND</u>			
24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE <u>4-15-72</u>	24C. NAME OF CEMETERY OR CREMATORY <u>ST. STANISLAUS Cem.</u>		24D. LOCATION (City, town, or county) (State) <u>BALTO. MD.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>APR 14 1972</u>		25B. NAME OF REGISTRAR <u>ROBERT J. ...</u>		25C. FUNERAL DIRECTOR <u>...-2331</u> ADDRESS <u>Jefferson St.</u>	

11/18/72 - meningitis, pneumococcus
Information from communicable
disease report from Church Home
& Hospital -
See Doc't file - Bur. of Vital
American Sldg
#

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

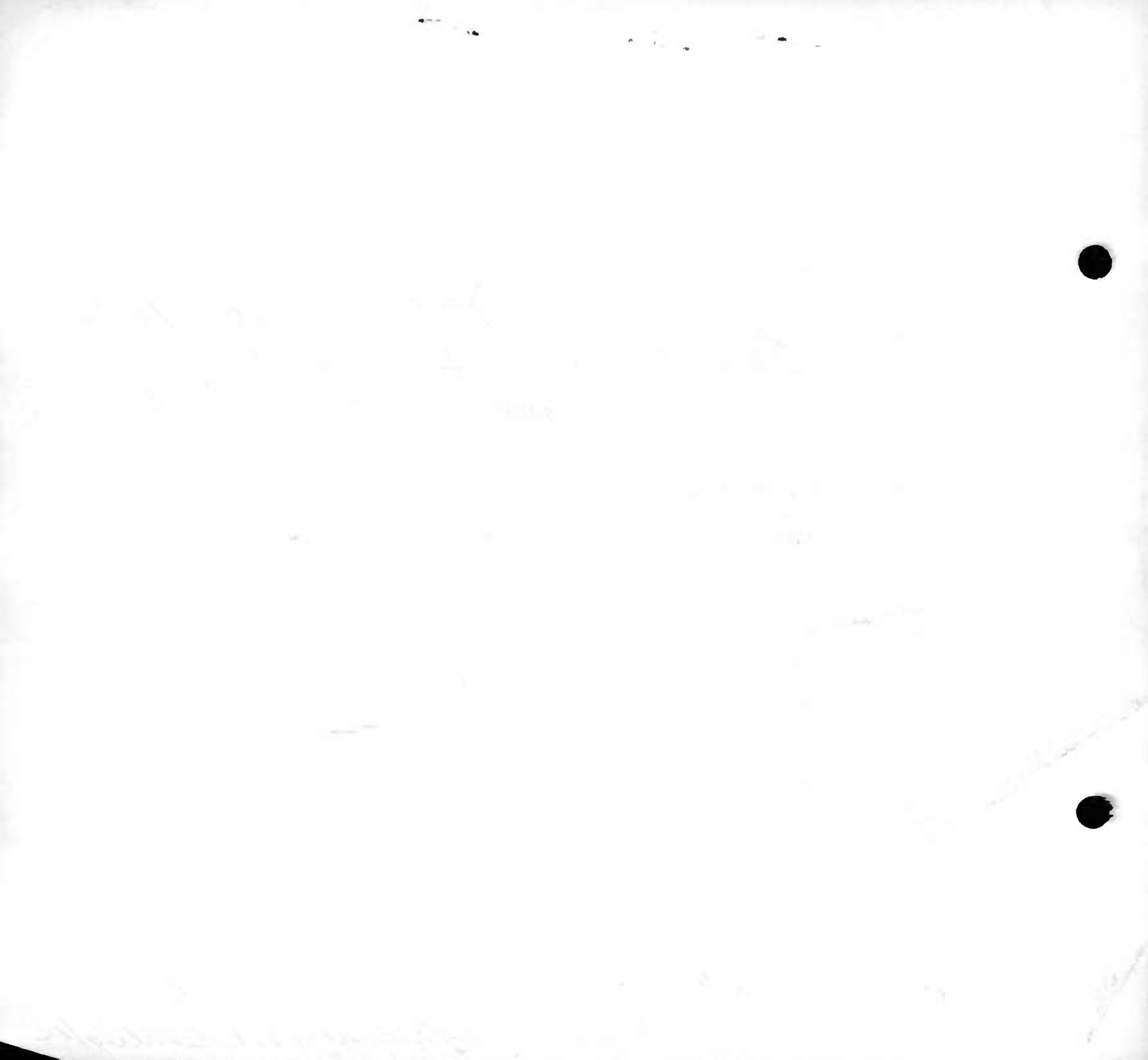
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>72 03594</u>	
S-315 BIRTH NO. <u>72 03594</u>		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) NORMAN LEON STEVENSON SR.		2. DATE AND HOUR OF DEATH 04-13-72 10:45P.		M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 33 JOHNS HOPKINS HOSPITAL 601 N. BROADWAY		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY 702		C. CITY OR TOWN BALTIMORE	
D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		E. STREET AND NUMBER 2620 ASHLAND AVENUE			
5. SEX White	6. RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-02-05	9. AGE (In years, last birthday) 66M	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PLUMBER		10B. KIND OF BUSINESS OR INDUSTRY PLUMBING		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME FRANK STEVENSON		14. MOTHER'S MAIDEN NAME MINNIE UNKNOWN	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 216 16 5507		17. INFORMANT Mrs. Madeline L. Stevenson - 2620 Ashland Ave.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) diffuse carcinomatosis		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: mucinous adenocarcinoma of stomach		(B) DUE TO, OR AS A CONSEQUENCE OF: Stomach	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 4-5		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Carcinoma of Stomach		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from April 1 19 72 to April 12 19 72 that (I) (we) last saw the deceased alive on April 12 19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE David K. Bone M.D.		23B. DATE SIGNED April 12, 1972		23C. PHYSICIAN'S NAME (Type) DAVID K. BONE, M.D.	
23D. ADDRESS JOHNS HOPKINS HOSPITAL		24A. BURIAL CREMATION, REMOVAL (Specify) CREMATION		24B. DATE 4-15-72	
24C. NAME OF CEMETERY or CREMATORY GREENMOUNT CREMATORY		24D. LOCATION (City, town, or county) (State) BALTO. MD.		25A. DATE REC'D BY HEALTH DEPT. APR 14 1972	
25B. NAME OF REGISTRAR Robert J. [illegible]		25C. FUNERAL DIRECTOR Arthur J. [illegible]		25D. ADDRESS 2334 Jefferson St.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burn; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
E-363 - 72 03595 - CERTIFICATE OF DEATH					REG. NO. 72 03595				
1. NAME OF DECEASED (Type or Print) EDWARDS, PAUL L.					2. DATE AND HOUR OF DEATH 4/9/72 11:30 pm M.				
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 42 SINAI HOSPITAL & BALTIMORE					4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MARYLAND B. COUNTY 2802 C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 4306 KATHMANDO AVE.				
5. SEX M	6. RACE Neg	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/3/23/44	9. AGE (in years lost birthday) 28	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11. BIRTHPLACE (State or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY USA
13. FATHER'S NAME Paul Edwards Sr.					14. MOTHER'S MAIDEN NAME Lessie Lofton				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No					16. SOCIAL SECURITY NO. 215-40-5738		17. INFORMANT Paul Edwards		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH CERTIFICATION APPROVED BY [Signature] M.D. CARDIO-RESPIRATORY ARREST ADDICTION DRUG OVERDOSE					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). ASPIRATION PNEUMONIA									
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 4306 KATHMANDO AVE.					
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?					
4/9/72		While At Work		FALL DOWN 4 STEPS					
22. I certify that (I) (this hospital) attended the deceased from 4/3/72 to 4/9/72 and that (I) (we) last saw the deceased alive on 4/9/72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE Harold T. Anderson Jr.								23B. DATE SIGNED 4/9/72	
23C. PHYSICIAN'S NAME (Type) SPENCER T. ORINOWSKI JR. M.D.								23D. ADDRESS SINAI HOSP of BALTO.	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY		24D. LOCATION (City, town, or county) (State)			
4- -72		April 14 1972		Brown Mt. Park		Balto Md			
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS			
APR 14 1972		Paul Edwards		Harold T. Anderson Jr.		1077 Broomfield			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <u>W-368 72 03596</u>				BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		REG. NO. <u>72 03596</u>	
1. NAME OF DECEASED (Type or Print) <u>WITHERSPOON, LAURA (JOHNSON)</u>				2. DATE AND HOUR OF DEATH <u>4-12-72</u> <u>11:30</u> A.M.					
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <u>48 Maryland General Hosp.</u> (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Balto.</u> B. COUNTY <u>Balto.</u> C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>821 Madison Ave.</u>					
5. SEX <u>F</u>	6. RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>7-9-26</u>	9. AGE (in years last birthday) <u>45</u>	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>			10B. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>South Carolina</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
13. FATHER'S NAME <u>Frank Witherspoon</u>			14. MOTHER'S MAIDEN NAME <u>Lulah McCray</u>						
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>			16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>Elnora Owens</u> ADDRESS <u>1235 Ashburton St</u>				
18. <u>436.01</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>CAUSE OF DEATH 220-30-6832</u> (A) IMMEDIATE CAUSE <u>Cerebral Vascular</u> DUE TO, OR AS A CONSEQUENCE OF: <u>Accident</u> (B) <u>—</u> DUE TO, OR AS A CONSEQUENCE OF: <u>Hypertension</u> (C) <u>—</u>			19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>II</u>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).									
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from <u>4/12/72</u> 19 <u>72</u> to <u>4/12/72</u> 19 <u>72</u> that (I) (we) last saw the deceased alive on <u>4/12/72</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <u>Ronald Kulp, M.D.</u> DEGREE				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>4/12/72</u>			
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS					
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Buried</u>		24B. DATE <u>4-15-72</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Ontario Cemetery</u>		24D. LOCATION (City, town, or county) <u>Ala County Md</u> (State)			
25A. DATE REC'D BY HEALTH DEPT. <u>APR 14 1972</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor, M.D.</u>		25C. FUNERAL DIRECTOR <u>Edwin 1000 Crumby St</u> ADDRESS					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO.	
W-235 72 03597				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH	
WESTMORELAND, JACK				APRIL 6, 1972 1:15AM M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION 33 JOHNS HOPKINS				A. STATE MARYLAND	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				B. COUNTY BALTIMORE	
				D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER 1346 N. WASHINGTON ST.	
5. SEX MALE	6. RACE BLACK	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-25-25	9. AGE (In years last birthday) 46	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Labor
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			11. BIRTH PLACE (State or foreign country) South Carolina	12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME westmoreland, walter			14. MOTHER'S MAIDEN NAME edwards, lucia		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes			16. SOCIAL SECURITY NO. 217-22-0828		
17. INFORMANT Evelyn Westmoreland			ADDRESS Same		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH Probable (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Probable Respiratory Arrest (B) Aspiration DUE TO, OR AS A CONSEQUENCE OF: (C) Acute Pancreatitis		
19. DATE OF OPERATION 4-5-72			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		
20A. AUTOPSY? (Yes or No) Yes			20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) No			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from 4-5 1972 to 4-6 1972 that (I) (we) last saw the deceased alive on 4-6 1972 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE J. Jones MD			23B. DATE SIGNED 4-6-72		
23C. PHYSICIAN'S NAME (Type) J. Jones			23D. ADDRESS M.D. The Johns Hopkins Hospital		
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 4-10-72		24C. NAME OF CEMETERY or CREMATORY ARBUTUS MEM PARK	
24D. LOCATION ARBUTUS MD.		24E. DATE REC'D BY HEALTH DEPT. APR 14 1972		24F. NAME OF REGISTRAR J. E. [unclear]	
24G. FUNERAL DIRECTOR E. G. WALSON		24H. ADDRESS 1000 BEANTLE AVE		24I. [unclear]	

W. A. R. 1991

72 03598

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

72 03598

BIRTH NO.

REG. NO.

1. NAME OF DECEASED (Type or Print) Abram H. Kittrell		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> 4 10 72 2:50 P.M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 00 288 S. Dallas Court		3. DATE PRONOUNCED DEAD Month Day Year Hour 4 10 72 2:50 P.M.	
6. SEX Male		7. RACE Negro	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore	
9. DATE OF BIRTH 4-9-72		10. AGE (In years last birthday) 56	
11. BIRTHPLACE (State or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Abraham Kittrell		14. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 361	
15. MOTHER'S MAIDEN NAME Dora Brunel		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give year or dates of service) No	
17. SOCIAL SECURITY NO. 27-07-5977		18. INFORMANT Shelia Kittrell	
19. 412.4 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
20A. DATE OF OPERATION 0		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) No			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, form, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?			
22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?			
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Deputy CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE Werner U. Spitz, M.D. DATE SIGNED 4-11-72 EXAMINER'S NAME (Type)			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4-15-72	
24C. NAME OF CEMETERY or CREMATORY Arbutus Cent		24D. LOCATION (City, town, or county) (State) Arbutus Cent	
25A. DATE REC'D BY HEALTH DEPT. APR 14 1972		25B. NAME OF REGISTRAR Robert E. [Signature]	
25C. FUNERAL DIRECTOR Wilson 1000 [Signature]		ADDRESS	

11-1-12
Northampton
3/4
10

11-1-12
Northampton
3/4
10

C-210

72 03599

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 72 03599

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

HILDA COSBY

2. DATE
OF
DEATHKnown ☐ Estimated ☐

Month

Day

Year

Hour

M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL
OR INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

605 Bridge View Rd. Apt. D

3. DATE
PRONOUNCED DEAD

Month

Day

Year

Hour

M.

4

10

1972

6:50 a

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Md.

B. COUNTY

2552

6. SEX

female

7. RACE

negro

8. MARRIED ☒ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

C. CITY OR TOWN

Balto.

D. INSIDE CITY LIMITS?

YES ☒NO ☐

9. DATE OF BIRTH

MAR 23-1930

10. AGE (In years
last birthday)

42

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

E. STREET AND NUMBER

605 Bridge View Rd. Apt. D

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

Joseph C Hall

14A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Housewife

14B. KIND OF BUSINESS OR INDUSTRY

None

15. MOTHER'S MAIDEN NAME

Bertha O Cook

16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

17. SOCIAL
SECURITY NO.

CAUSE OF DEATH

Fatty infiltration of liver

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, ashenia, etc. It means the disease,
injury or complication which caused death.)

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART I (A).

20A. DATE OF OPERATION 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

yes

22A. EXTERNAL CAUSE WAS
UNDERLYING ☐ OR CONTRIB-
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg., etc.)22C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?22D. TIME (Month) (Day) (Year) (Hour)
OF INJURY
(APPROX.)

22E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Russell S. Fisher, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☒ASSISTANT MEDICAL EXAMINER ☐ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

4-10-72

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

4-14-72

24C. NAME OF CEMETERY or CREMATORY

Magothy Court

24D. LOCATION (City, town, or county)

All County

(State)

25A. DATE REC'D BY HEALTH DEPT.

APR 14 1972

25B. NAME OF REGISTRAR

R. S. Fisher

25C. FUNERAL DIRECTOR

Shoy Wilson

ADDRESS

1000 Broadway

00000 57

00000 57

62

James C. Cook
John C. Cook
John C. Cook

James C. Cook
John C. Cook

VALLEY FORGE

25-27th JANUARY

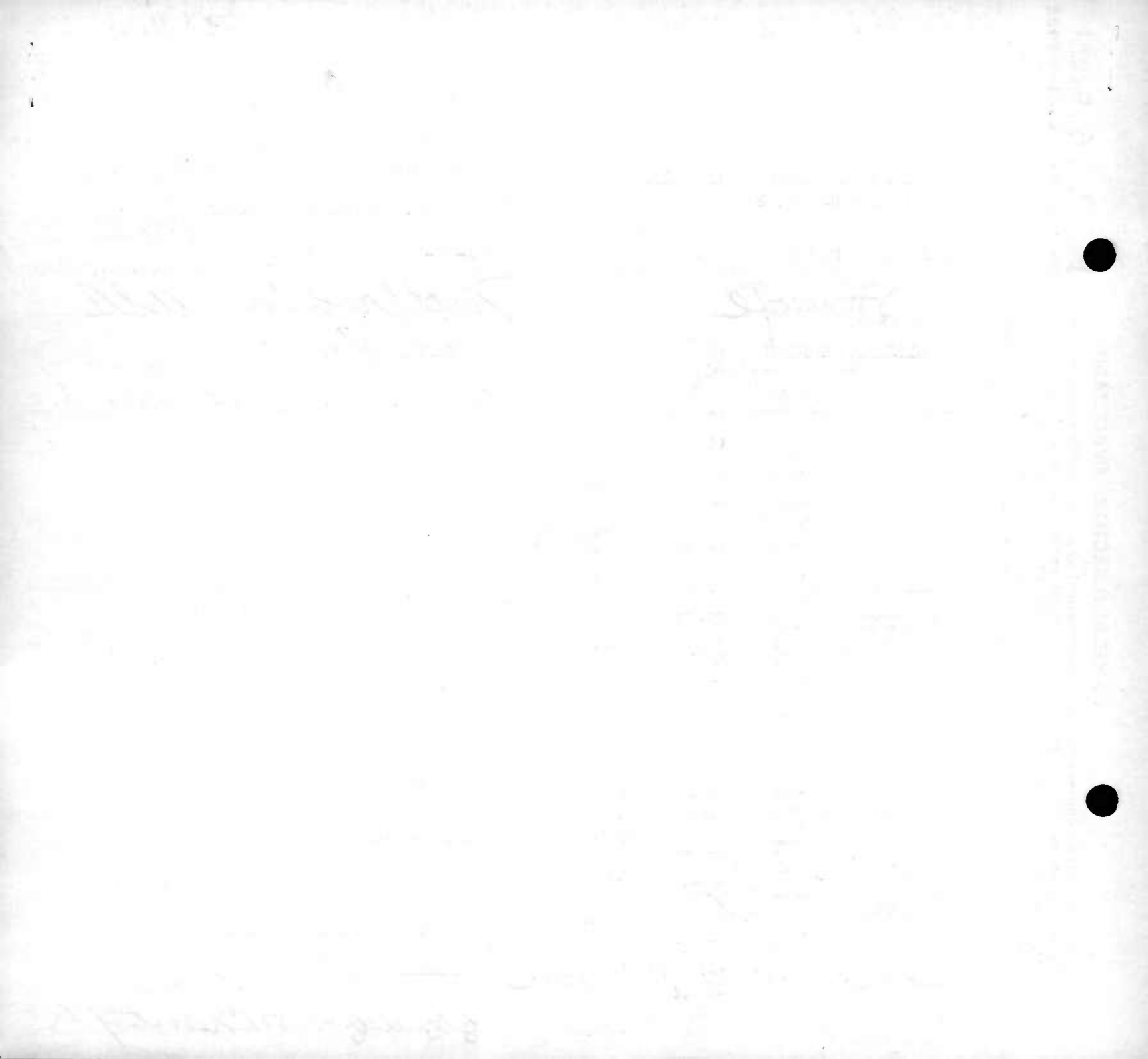
1862

James C. Cook
John C. Cook
John C. Cook

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

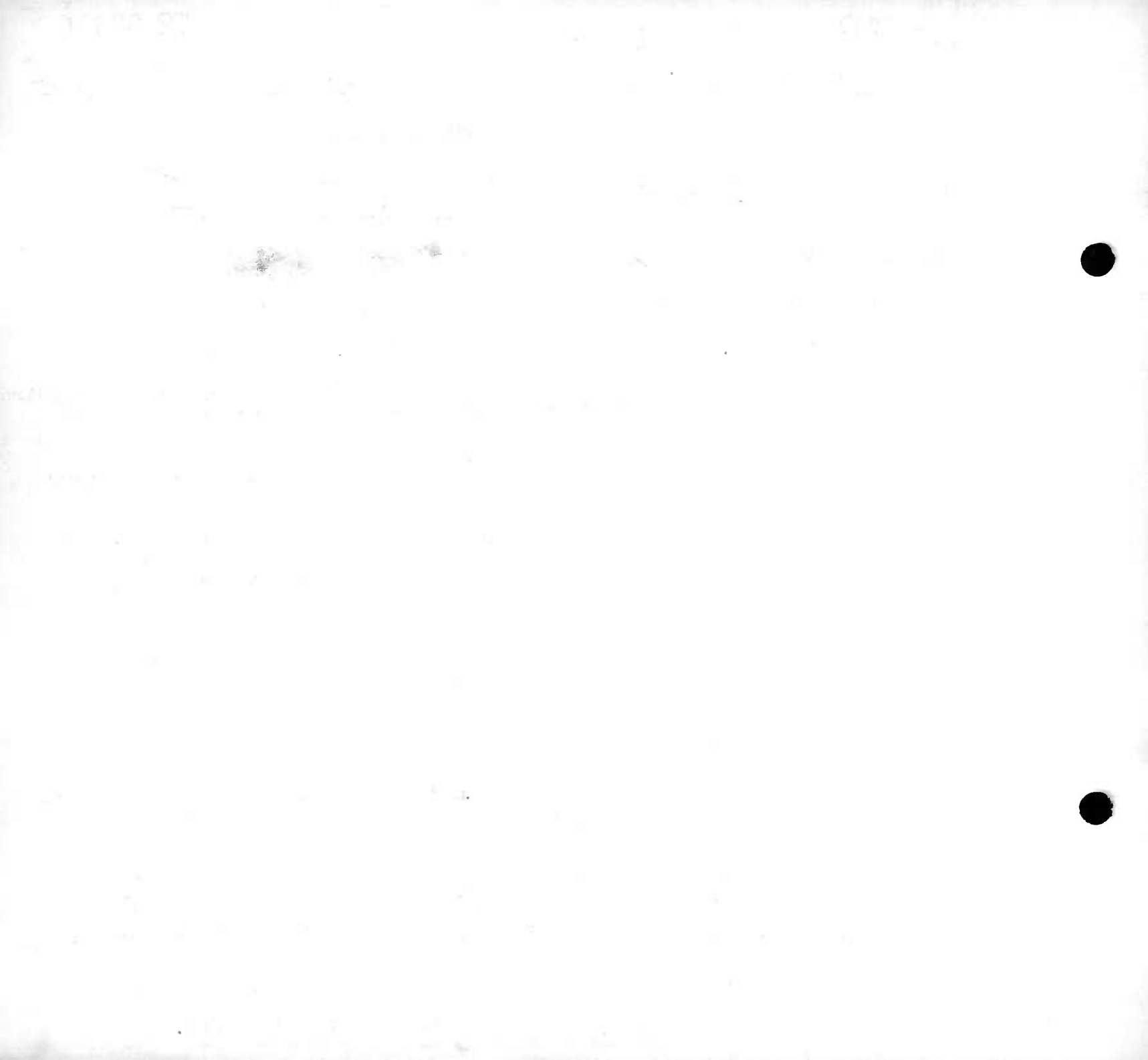
BALTIMORE CITY HEALTH DEPARTMENT				CERTIFICATE OF DEATH		REG. NO. 72 03600	
BIRTH NO. 3-424 72 03600				1. NAME OF DECEASED (Type or Print) Eleanor Blackwell		2. DATE AND HOUR OF DEATH April 7, 1972 3:45 pm M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission), A. STATE MARYLAND B. COUNTY 704			
FULL NAME OF HOSPITAL OR INSTITUTION		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
33 THE JOHNS HOPKINS HOSPITAL		BALTIMORE, MD 21205		E. STREET AND NUMBER 821 N. WASHINGTON STREET			
5. SEX FEMALE	6. RACE NEGRO	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 03-01-14	9. AGE (In years last birthday) 58	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Jones & Co.			11. BIRTHPLACE (State or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME WILLIAM JOHNSON			14. MOTHER'S MAIDEN NAME FANNIE Piney				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) 24			16. SOCIAL SECURITY NO.		17. INFORMANT Thomas Blackwell		ADDRESS
18. 037.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Cardiac Pulmonary Arrest			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 15 min	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(B) Hypotension DUE TO, OR AS A CONSEQUENCE OF:			5 hrs	
			(C) Septic Shock, Ascites, Urinary tract Infection, Cirrhosis, Cardiomyopathy, CHF				
II							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 8:00 am April 7 1972 to 3:45 pm 4/7 1972 that (I) (we) last saw the deceased alive on April 7 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Barry Cooper MD				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 4/7/72	
23C. PHYSICIAN'S NAME (Type) Barry Cooper MD				23D. ADDRESS THE JOHNS HOPKINS HOSPITAL			
24A. BURIAL CREMATION REMOVAL (Specify)		24B. DATE 4-13-72		24C. NAME OF CEMETERY or CREMATORY Mt Auburn		24D. LOCATION (City, town, or county) (State) Baltimore MD	
25A. DATE REC'D BY HEALTH DEPT. APR 14 1972		25B. NAME OF REGISTRAR Robert E. Taylor MD		25C. FUNERAL DIRECTOR		ADDRESS 1000 Cranberry Ln	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

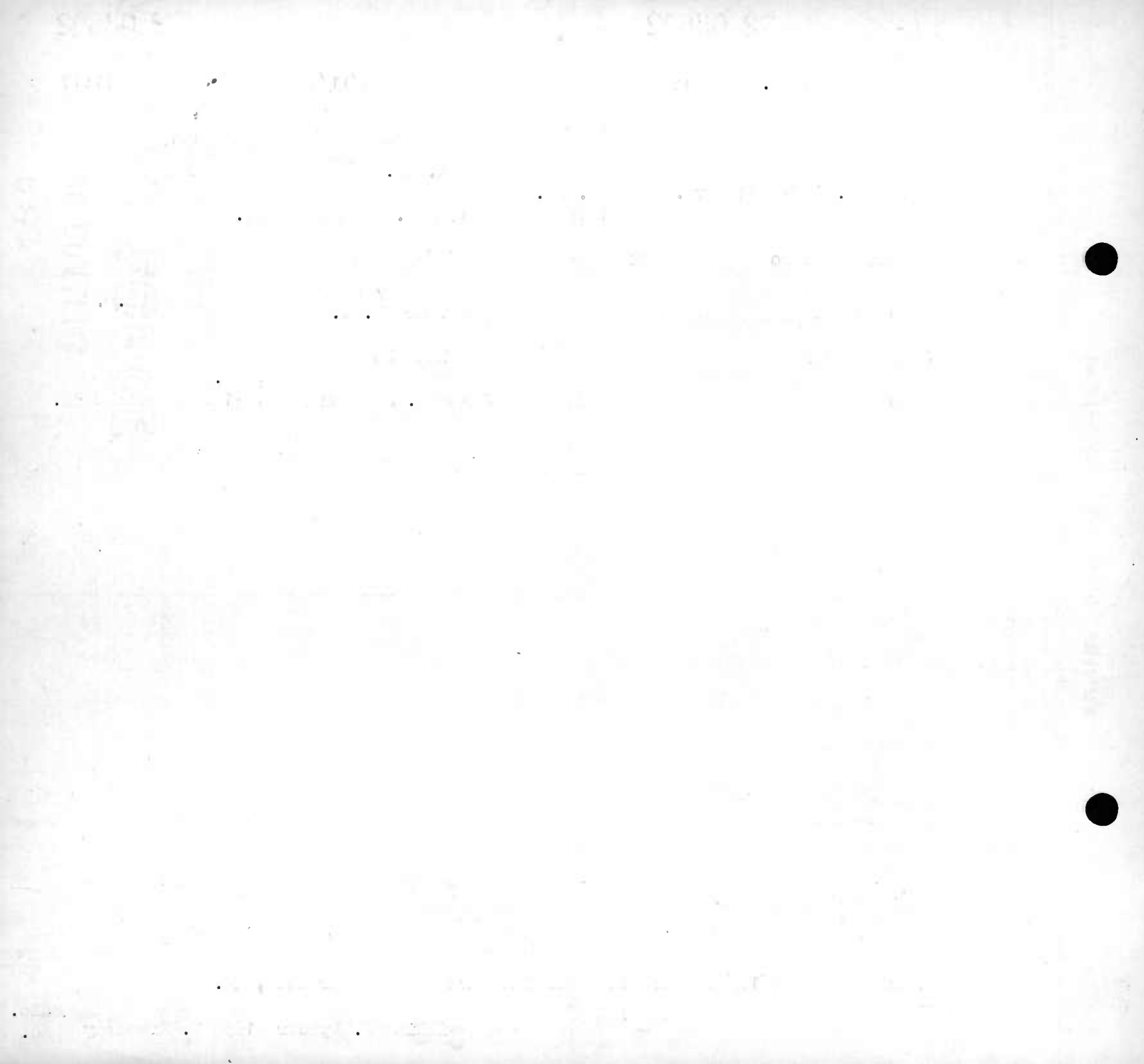
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>72 03601</u>
1. NAME OF DECEASED (Type or Print) <u>Henry A. Lounge</u>		2. DATE AND HOUR OF DEATH <u>4/12/72</u> <u>5:45</u> P.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <u>Bolton Hill Nursing & Convalescent Center</u>		A. STATE <u>MARYLAND</u> B. COUNTY <u>806</u>		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN <u>BALTIMORE</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
E. STREET AND NUMBER <u>1826 Dallas Street</u>				
5. SEX <u>male</u>	6. RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4/5/1900</u>	9. AGE (in years) <u>72</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Repairman AT&T</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>
12. CITIZEN OF WHAT COUNTRY		13. FATHER'S NAME <u>Joseph M. Lounge</u>		
14. MOTHER'S MAIDEN NAME <u>Annie B. Freshlein</u>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		
16. SOCIAL SECURITY NO. <u>212-63-6730</u>		17. INFORMANT <u>Mrs Gertrude Silberzahn</u> ADDRESS <u>806 Mockingbird Lane 21204</u>		
18. <u>4/12/72</u> CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE <u>Myocardial Infarction</u> years DUE TO, OR AS A CONSEQUENCE OF: (B) <u>arteriosclerosis heart disease</u> years DUE TO, OR AS A CONSEQUENCE OF: (C) <u>arteriosclerosis generalized</u> years		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>NO</u>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from <u>4/12</u> 19 <u>69</u> to <u>4/12</u> 19 <u>72</u> that (I) (we) last saw the deceased alive on <u>4/12</u> 19 <u>72</u> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <u>Alan H. Mochtmann</u>		23B. DATE SIGNED <u>4/12/72</u>		23C. PHYSICIAN'S NAME (Type) <u>ALAN H. MOCHTMANN</u>
23D. ADDRESS <u>2 E. Reed St. Balt Md 21202</u>		24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		
24B. DATE <u>4/15/72</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Most Holy Redeemer</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>
25A. DATE REC'D BY HEALTH DEPT. <u>APR 14 1972</u>		25B. NAME OF REGISTRAR <u>John E. J. J. J.</u>		25C. FUNERAL DIRECTOR <u>Henry Sander & Sons Inc.</u>
ADDRESS				



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such approval must be obtained before the remains are embalmed or final disposition is made.

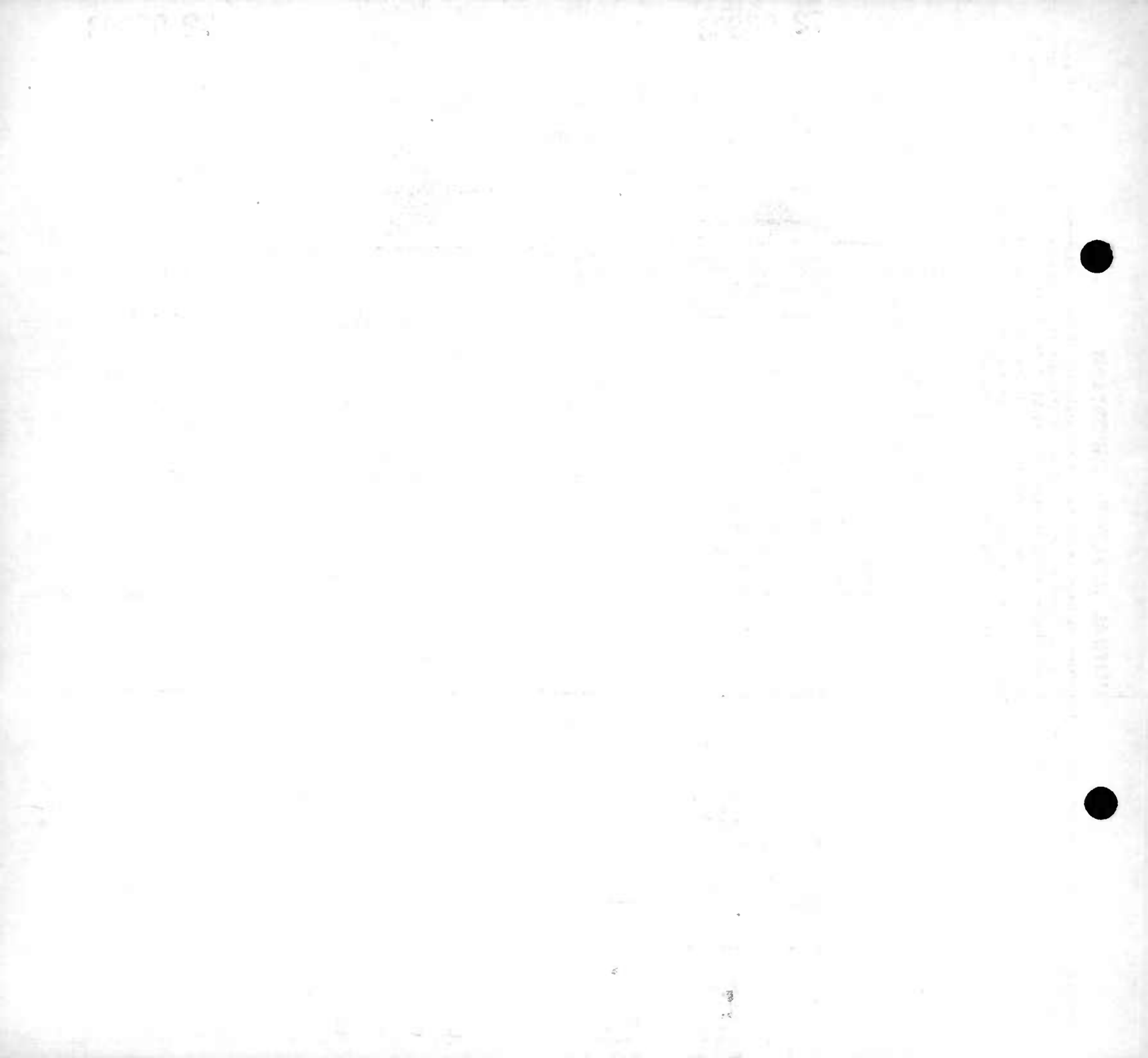
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 03602	
<div style="display: flex; justify-content: space-between;"> J-525 72 03602 </div>					
<div style="display: flex; justify-content: space-between;"> BIRTH NO. CERTIFICATE OF DEATH </div>					
1. NAME OF DECEASED (Type or Print) Nancy L. Johnson			2. DATE AND HOUR OF DEATH <div style="display: flex; justify-content: space-between;"> 4/11/72 11:17 P.M. </div>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE B. COUNTY		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 001728 E. Lafayette Ave. Balt. Md. 21213			C. CITY OR TOWN D. INSIDE CITY LIMITS? Baltimore, Maryland 21213 806 Balt. Md. YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
5. SEX Female			6. RACE Negro		
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH 5/6/83		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			9. AGE (In years last birthday) 88		
10B. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country) Woodward S. C.		
12. CITIZEN OF WHAT COUNTRY? U.S.			13. FATHER'S NAME Joseph Foster		
14. MOTHER'S MAIDEN NAME Ellen Jones			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		
16. SOCIAL SECURITY NO. None			17. INFORMANT James R. Johnson Box 1511 Manderville Rd.		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Acute myocardial Infarction			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 Day		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Arteriosclerosis			6 Years		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 2-17-1966 to 4-11-1972, that (I) (we) lost saw the deceased alive on 4-11-1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Eugene Owens</i>				23B. DATE SIGNED 4-14-72	
23C. PHYSICIAN'S NAME (Type) Eugene Owens				23D. ADDRESS 1735 E. Federal St	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4/17/72		24C. NAME of CEMETERY or CREMATORY Arbutus Memorial Park	
24D. LOCATION (City, town, or county) (State) Arbutus, Md.		25A. DATE REC'D BY HEALTH DEPT. APR 14 1972			
25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR William J. Spicer			
ADDRESS Balt. Md.		1639 N. Broadway			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

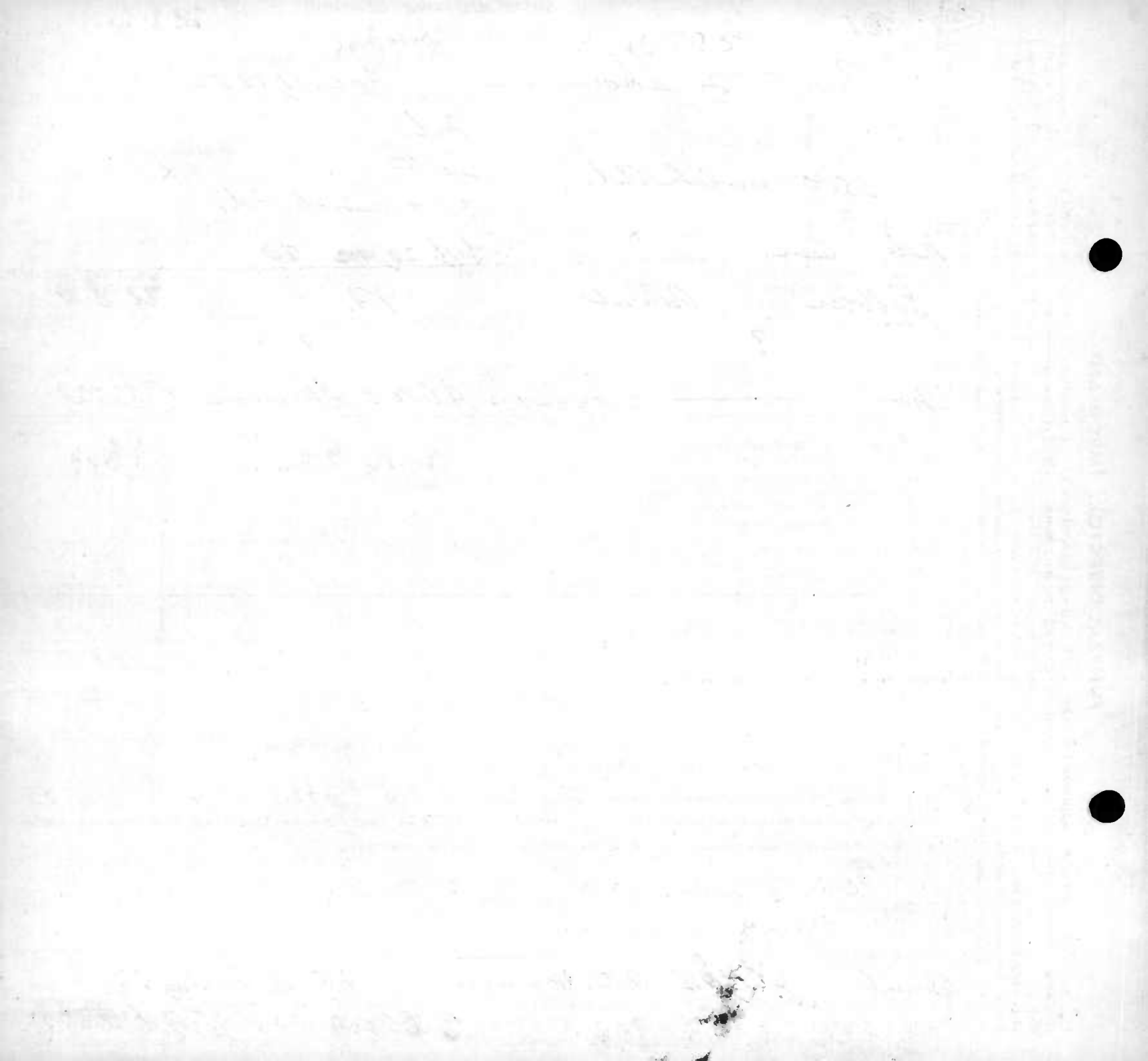
Baltimore City Health Department				REG. NO. 72 03603	
C-400 72 03603		BIRTH NO.			
1. NAME OF DECEASED (Type or Print) Leo Coll			2. DATE AND HOUR OF DEATH 4/11/72 1:30 p.m.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 37 Mercy Hospital, Inc.			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Md. B. COUNTY 901		
5. SEX Male		6. RACE Caucasian	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1-5-8
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Auditor		10B. KIND OF BUSINESS OR INDUSTRY Race Track		9. AGE (in years lost birthday) 64 If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
11. BIRTHPLACE (State or foreign country) Maryland			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME LEO Coll			14. MOTHER'S MAIDEN NAME unobtainable		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 213-18-3221		17. INFORMANT M. Albert Coll, 3818 Delverne Rd. 21218	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 560.21 Acute renal Failure 1wk			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. (B) Volvulus of Cecum 2 wks (C) Bronchogenic Carcinoma 4 mos Electrolyte imbalance					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 3/29/72		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Volvulus of Cecum		20A. AUTOPSY (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 3/14 19 72 to 4/11 19 72 that (I) (we) last saw the deceased alive on 4/11/72 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Louis A. Spritz MD				23B. DATE SIGNED 4/11/72	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS Mercy Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify) burial		24B. DATE 14 Apr. 72		24C. NAME of CEMETERY or CREMATORY Most Holy Redeemer Cemetery Balto., Md. 21206	
25A. DATE REC'D BY HEALTH DEPT. APR 14 1972		25B. NAME OF REGISTRAR Robert E. Miller MD		25C. FUNERAL DIRECTOR ADDRESS 4210 Belair	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
REG. NO. 72 03604									
<div style="display: flex; justify-content: space-between;"> 5-550 72 03604 CERTIFICATE OF DEATH </div>									
<div style="display: flex; justify-content: space-between;"> <div> BIRTH NO. 1. NAME OF DECEASED (Type or Print) <i>Robert L. Shouman</i> </div> <div> 2. DATE AND HOUR OF DEATH <i>Apr. 11, 1972</i> </div> </div>									
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <i>00 3500 Kemwick Rd.</i>					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Ind.</i> B. COUNTY <i>1306</i> C. CITY OR TOWN <i>Ind.</i> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <i>3500 Kemwick Rd.</i>				
5. SEX <i>Male</i>		6. RACE <i>Cauc.</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>Feb. 20, 1902</i>		9. AGE (In years lost birthday) <i>70</i>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Laborer</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Retired</i>		11. BIRTHPLACE (State or foreign country) <i>PA.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>			
13. FATHER'S NAME <i>?</i>					14. MOTHER'S MAIDEN NAME <i>?</i>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>					16. SOCIAL SECURITY NO. <i>220-140913A</i>		17. INFORMANT <i>Alice E. Shouman</i>		
					ADDRESS <i>(Same)</i>				
18. CAUSE OF DEATH <div style="display: flex; justify-content: space-between;"> <div> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. </div> <div> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Coronary Thrombosis</i> </div> <div> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>3 days</i> </div> </div>									
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).									
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <i>4-10</i> 1972 to <i>4-11</i> 1972 that (I) (we) last saw the deceased alive on <i>4-10</i> 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
23A. SIGNATURE <i>Reuben Hoffman, M.D.</i>					Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>			23B. DATE SIGNED <i>4-13-72</i>	
23C. PHYSICIAN'S NAME (Type) <i>REUBEN HOFFMAN, M.D.</i>					23D. ADDRESS				
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>Apr. 15, 1972</i>		24C. NAME OF CEMETERY or CREMATORY <i>Int. Herman</i>		24D. LOCATION (City, town, or county) (State) <i>Int. Jackson, Pa.</i>			
25A. DATE REC'D BY HEALTH DEPT. <i>APR 14 1972</i>		25B. NAME OF REGISTRAR <i>Reuben Hoffman</i>		25C. FUNERAL DIRECTOR <i>Reuben Hoffman</i>		ADDRESS <i>3617 Chestnut Av.</i>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-653 72 03605		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 03605	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) Robert Frederick Brandt		2. DATE AND HOUR OF DEATH April 12, 1972 1:35 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Western Electric Hospital (2500 BROENING Highway, Balto. City, Md.)		4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE Maryland B. COUNTY Harford Co. 6232 C. CITY OR TOWN Bel Air D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 516 Idlewild Rd.			
5. SEX Male	6. RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH January 19, 1928	9. AGE (In years lost birthday) 44	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Public Relations Manager		10B. KIND OF BUSINESS OR INDUSTRY Communications		11. BIRTHPLACE (State or foreign country) Cleveland, Ohio	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Robert Frederick Brandt		14. MOTHER'S MAIDEN NAME Grace Doolittle	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES - NAVY 2-21-46 to 12-24-47		16. SOCIAL SECURITY NO. 291-20-1569		17. INFORMANT (Last) 838-8702 Mrs. Joan L. Brandt 516 Idlewild Road Bel Air, Maryland 21014	
18. 4/10/72 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ACUTE MYOCARDIAL INFARCTION TIMED.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, form, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 4/12/72 ON 4/12/72 1972 and that (I) (we) last saw the deceased alive on 4/12/72 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Bernard J. Burnes Jr. M.D. DEGREE		WESTERN ELECTRIC CO. PHYSICIAN Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 4/12/72	
23C. PHYSICIAN'S NAME (Type) BERNARD J. BURNES JR. M.D. DEGREE		23D. ADDRESS 2500 BROENING HWY BALTIMORE, MD 21224			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE Apr. 15, 1972		24C. NAME OF CEMETERY or CREMATORY Bel Air Memorial Gardens	
24D. LOCATION (City, town, or county) (State) Bel Air, Harford Co., Maryland 21014					
25A. DATE REC'D BY HEALTH DEPT. APR 14 1972		25B. NAME OF REGISTRAR John E. Fisher M.D.		25C. FUNERAL DIRECTOR Joseph William Foster W. Broadway & Williams St. Bel Air, Maryland 21014	

[Faint, illegible handwriting throughout the page, likely bleed-through from the reverse side. The text is too light to transcribe accurately.]

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 03606	
BIRTH NO. 72 03606		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <i>Elsie Margant Dalziel</i>		2. DATE AND HOUR OF DEATH <i>4/13/72</i> <i>3:30 A.</i> M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <i>D.O.A. Soth Balto Gen Hospital</i>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>Md</i> B. COUNTY <i>2533</i>			
		C. CITY OR TOWN <i>Baltimore</i>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER <i>2341 Sidney Ave Balto Md. 21230</i>			
5. SEX <i>F</i>	6. RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Feb 20 1902</i>	9. AGE (In years last birthday) <i>70</i>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY <i>Housewife</i>		11. BIRTHPLACE (State or foreign country) <i>Canada</i>	
12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		13. FATHER'S NAME <i>William Nesbit</i>		14. MOTHER'S MAIDEN NAME <i>Unknown</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>218 50 7344</i>		17. INFORMANT ADDRESS <i>James R. Dalziel 5003 Sipple Ave 21206</i>	
18. <i>4/10/01</i> CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Coronary Thrombosis</i> (B) <i>Hypertension C. V. D.</i> (C) <i>Pneumonia</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>1 day</i> <i>8 years</i> <i>7 days</i>	
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from <i>1940</i> to <i>April 13 1972</i> , that (I) (we) last saw the deceased alive on <i>April 11 1972</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <i>Paul Schuchard</i>		23B. DATE SIGNED <i>4/13/72</i>		23C. PHYSICIAN'S NAME (Type) <i>Paul Schuchard</i>	
23D. ADDRESS <i>7301 Annapolis Rd Baltimore 30 Md.</i>		24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>4/17/72</i>	
24C. NAME OF CEMETERY or CREMATORY <i>Meadowridge Cemetery</i>		24D. LOCATION (City, town, or county) (State) <i>Donsey Md. Washington Blvd</i>		25A. DATE REC'D BY HEALTH DEPT. <i>APR 14 1972</i>	
25B. NAME OF REGISTRAR <i>Paul E. Schuchard</i>		25C. FUNERAL DIRECTOR ADDRESS <i>McJully Funeral Home 237 'atapsco Ave 21225</i>			



72 03607

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

72 03607

BIRTH NO.

1. NAME OF DECEASED

(Type or Print)

Mary (May Williams) Phillips

2. DATE OF DEATH

Known ☒ Estimated ☐

Month 4

Day 7

Year 72

Hour

M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

2926 Westwood Avenue

3. DATE PRONOUNCED DEAD

Month 4

Day 7

Year 72

Hour 8:00 p.

M.

5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE Md.

B. COUNTY

1506

6. SEX

female

7. RACE

Negro

8. MARRIED ☐ NEVER MARRIED ☒WIDOWED ☐DIVORCED ☐

C. CITY OR TOWN

Balto.

D. INSIDE CITY LIMITS?

YES ☐NO ☐

9. DATE OF BIRTH

4-27-29

10. AGE (In years last birthday)

42

If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.

E. STREET AND NUMBER

2926 Westwood Avenue

11. BIRTHPLACE (State or foreign country)

North Carolina

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

Eddie Phillips

14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

Ethel McDougald

16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

17. SOCIAL SECURITY NO.

18. INFORMANT

ADDRESS

Eva McCoy 1202 Eutaw Place

19.

671.81

CAUSE OF DEATH

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

Cirrhosis of liver

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

yes

22A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

22E. INJURY OCCURRED

WHILE AT WORK ☐NOT WHILE AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinionresulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE

EXAMINER'S NAME (Type)

Peter Lipkovic, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

4/8/72

24A. BURIAL CREMATION, REMOVAL (Specify)

Burial

24B. DATE

4-14-72

24C. NAME of CEMETERY or CREMATORY

Mt Auburn Cemetery

24D. LOCATION (City, town, or county)

Balto., Md.

(State)

25A. DATE REC'D BY HEALTH DEPT.

25B. NAME OF REGISTRAR

25C. FUNERAL DIRECTOR

ADDRESS

APR 14 1972

Robert E. Fisher, M.D.

Wm C March

928 E North Ave.

18-03012

EXHIBIT 18-03012

Handwritten signature

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

REG. NO.

72 03608

BIRTH NO. <u>72 03608</u>		2. DATE AND HOUR OF DEATH <u>April 12, 1972</u> <u>1:10</u> P.M.	
1. NAME OF DECEASED (Type or Print) <u>PEACE, Robin R.</u>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>2562</u>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>33 Johns Hopkins Hospital</u>		C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <u>Female</u>		6. RACE <u>Negro</u>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>11/16/66</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		9. AGE (In years (last birthday)) <u>5</u> If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
13. FATHER'S NAME <u>Walter Smith</u>		12. CITIZEN OF WHAT COUNTRY?	
14. MOTHER'S MAIDEN NAME <u>Addelbert Anita Peace</u>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <u>Addelbert Peace 2908 Cherryland Rd.</u>	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>II</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <u>Juvenile Rheumatoid arthritis; hepatitis</u>			
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>6 hours</u>			
(A) IMMEDIATE CAUSE <u>Cardio-respiratory arrest</u> DUE TO, OR AS A CONSEQUENCE OF:			
(B) <u>Metabolic Acidosis</u> DUE TO, OR AS A CONSEQUENCE OF:			
(C) <u>????????</u>			
MEDICAL CERTIFICATION 19A. DATE OF OPERATION <u>21</u> 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 20A. AUTOPSY? (Yes or No) <u>Yes</u> 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>NO</u>			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (the undersigned) attended the deceased from <u>April 8</u> 19 <u>72</u> to <u>April 12</u> 19 <u>72</u> that (I) <u>did</u> last saw the deceased alive on <u>April 12</u> 19 <u>72</u> and that in (my) <u>own</u> opinion death occurred on the date and hour and from the causes stated above. (I) <u>did</u> (did not) view the body after death.			
23A. SIGNATURE <u>Jerrold C. Woodhead, MD</u>		23B. DATE SIGNED <u>April 12, 1972</u>	
23C. PHYSICIAN'S NAME (Type) <u>Jerrold C. Woodhead, MD</u>		23D. ADDRESS <u>Johns Hopkins Hospital Balto., Md.</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>4-17-72</u>	
24C. NAME OF CEMETERY OR CREMATORY <u>Balto. Cemetery</u>		24D. LOCATION (City, town, or county) (State) <u>Balto., Md.</u>	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR	
25C. FUNERAL DIRECTOR <u>Wm C March</u>		ADDRESS <u>928 E North Ave.</u>	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>72 03609</u>
BIRTH NO. <u>72 03609</u>		CERTIFICATE OF DEATH		
1. NAME OF DECEASED (Type or Print) <u>(Baby Girl) Hardy, Michele D</u>		2. DATE AND HOUR OF DEATH <u>4/12/72 6:30 AM</u>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <u>Univ. Hosp.</u>		4. USUAL RESIDENCE (Where deceased lived, if institutions: residence before admission) A. STATE <u>MD</u> B. COUNTY <u>805</u>		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>Univ. Hosp.</u>		C. CITY OR TOWN <u>Balt. Md</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
5. SEX <u>F</u>		6. RACE <u>B</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		8. DATE OF BIRTH <u>4/10/72</u>		9. AGE (In years last birthday) <u>2</u>
10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Union Mem. Hosp.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>WAYNE BAZEMORE</u>		14. MOTHER'S MAIDEN NAME <u>Diane Hardy</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Mrs Rita Hardy-2029 Sinclair Lane</u>
18. <u>72.0 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>Respiratory Arrest</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last <u>Intracerebral Hemorrhage</u>				
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				
19A. DATE OF OPERATION <u>4/11/72</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from <u>4/11/72</u> 19 <u>72</u> to <u>4/12/72</u> 19 <u>72</u> that (I) (we) last saw the deceased alive on <u>4/11/72</u> 19 <u>72</u> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <u>R. Lucas MD</u>		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED
23C. PHYSICIAN'S NAME (Typo) <u>R. Lucas</u>		23D. ADDRESS		
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>4/15/72</u>		24C. NAME OF CEMETERY OR CREMATORY <u>New Cathedral Cemetery</u>
24D. LOCATION <u>Batts. Md.</u>		25A. DATE REC'D BY HEALTH DEPT. <u>APR 14 1972</u>		
25B. NAME OF REGISTRAR <u>Robt E. J. ...</u>		25C. FUNERAL DIRECTOR <u>Wm. C. March</u>		
25D. ADDRESS <u>975 E. North Ave</u>				



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

72 03610

BIRTH NO.

1. NAME OF DECEASED (Type or Print) REASON M. CHASE		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> April 12, 1972		3. DATE PRONOUNCED DEAD Month Day Year Hour April 12, 1972 6:20 P.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 00 304 E. Lanvale Street		5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY 1205			
6. SEX Male	7. RACE Negro	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
9. DATE OF BIRTH 9-13-98		10. AGE (In years last birthday) 74	E. STREET AND NUMBER 304 E. Lanvale Street		
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME Reason S. Chase	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		14B. KIND OF BUSINESS OR INDUSTRY		15. MOTHER'S MAIDEN NAME Ellen Chase	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO. 214-14-9195		18. INFORMANT ADDRESS Mrs. Mable Chase 3438 Auchentroly Ter	
19. 412.21 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Hypertensive and arteriosclerotic cardiovascular disease		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
20A. DATE OF OPERATION 0		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) No	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (if in Baltimore City, give exact location) INJURY OCCUR?	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Charles S. Springate M.D. EXAMINER'S NAME (Type) Charles S. Springate, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED April 13, 1972					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4-15-72		24C. NAME of CEMETERY or CREMATORY Mt Auburn Cemetery	
24D. LOCATION (City, town, or county) (State) Balto., Md.					
25A. DATE REC'D BY HEALTH DEPT. APR 14 1972		25B. NAME OF REGISTRAR Robert E. Farber, M.D.		25C. FUNERAL DIRECTOR ADDRESS Wm C March 928 E North Ave.	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>72 03611</u>	
BIRTH NO. <u>M 2572 03611</u>				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <u>JAMES EDWARD MC CONNELL</u>			2. DATE AND HOUR OF DEATH <u>April 12, 1972</u> <u>3:20</u> <u>P</u>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>US Public Health Service Hospital</u> <u>3100 Wyman Parkway</u>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Md.</u> B. COUNTY <u>1204</u> C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>426 E. 22nd Street</u>		
5. SEX <u>M</u>	6. RACE <u>Negro</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7/8/37</u>	9. AGE (In years last birthday) <u>34</u>	If Under 1 Yr. Months _____ Days _____ If Under 24 Hrs. Hours _____ Min. _____
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>USAF</u>		11. BIRTHPLACE (State or foreign country) <u>Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			13. FATHER'S NAME <u>Edward Alexander</u>		
14. MOTHER'S MAIDEN NAME <u>Loerona Skinner</u>			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>Yes</u> <u>USAF 1965-1972</u>		
16. SOCIAL SECURITY NO. <u>212-34-4021</u>			17. INFORMANT <u>Records- US PHS Hospital, Balto, Md.</u>		
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Acute bilateral broncho-</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Anaplastic carcinoma of left upper lung with widespread metastases</u>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Days</u> <u>9 mos.</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>yes</u>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>yes</u>		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (if this hospital) attended the deceased from <u>Feb. 14</u> 19 <u>72</u> to <u>Apr. 12</u> 19 <u>72</u>, that (if we) last saw the deceased alive on <u>Apr. 12</u> 19 <u>72</u> and that in (if our) opinion death occurred on the date and hour and from the causes stated above. (if We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Robert E. Wright, SA Surg (R)</u>				23B. DATE SIGNED <u>4/13/72</u>	
23C. PHYSICIAN'S NAME (Type or Print) <u>Robert E. Wright, SA Surg (R)</u>				23D. ADDRESS <u>US PHS Hospital, Balto, Md. 21211</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>4-17-72</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Arlington National Cem. Arlington, Va.</u>	
24D. LOCATION (City, town, or county) (State) <u>Arlington, Va.</u>		25A. DATE REC'D BY HEALTH DEPT. <u>APR 14 1972</u>			
25B. NAME OF REGISTRAR <u>Robert E. Taylor, M.D.</u>		25C. FUNERAL DIRECTOR <u>Wm. C March</u> <u>928 E North Ave.</u>			

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

14 520

72 03612

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

REG. NO. 72 03612

BIRTH NO. 72 03612		1. NAME OF DECEASED (Type or Print) SUMPTER N. HINES Jr		2. DATE AND HOUR OF DEATH 12 APR. 72, 8:20 A. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) UNIV. OF MD. HOSPITAL LOMBARD + GREEN ST. BALTIMORE, MD.			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY 1403 C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 1928 N BRUNT ST. 21217		
5. SEX M	6. RACE N	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-17-22	9. AGE (in years last birthday) 49	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) UNEMPLOYED		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) GEORGIA		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME SUMPTER HINES			14. MOTHER'S MAIDEN NAME ROSA		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 257 22 2420	17. INFORMANT ADDRESS Mr. Freddie Hines 1150 Myrtle Ave.		
18. CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: BILATERAL TUBERCULOSIS (INACTIVE) BULLAE EMPHYSEMA		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 YRS 25 YRS 10 YRS
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). ULCERATIVE COLITIS					
19A. DATE OF OPERATION 1944		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED BRONCHIAL NERVE CRUIST		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from 4/3 1972 to 4/12 1972 that (2) (we) last saw the deceased alive on 4/11 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE P. A. MACIKOWIAK			23B. DATE SIGNED 4/12/72		23C. PHYSICIAN'S NAME (Type) P. A. MACIKOWIAK
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4/18/72		24C. NAME OF CEMETERY OR CREMATORY Mt. Auburn	
25A. DATE REC'D BY HEALTH DEPT. APR 14 1972		25B. NAME OF REGISTRAR Mary-E. Law		25C. FUNERAL DIRECTOR 802 Madison Ave	

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BIRTH NO.

REG. NO.

1. NAME OF DECEASED (Type or Print) Matthew Johnson		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month 4 Day 8 Year 72 Hour M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Lutheran Hospital		3. DATE PRONOUNCED DEAD Month 4 Day 8 Year 72 Hour 11:05 p. M.	
5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY 1607			
6. SEX male	7. RACE Negro	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH 5/19/23		10. AGE (In years lost birthday) 49 If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) Harford Co. Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret.	
15. MOTHER'S MAIDEN NAME Nellie Johnson		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give year or dates of service) No	
17. SOCIAL SECURITY NO. 215 22-444		18. INFORMANT ADDRESS Mrs. E. Dodd 2747 Winchester St.	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Conflagration ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) yes			
22A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. <input checked="" type="checkbox"/> UNDERLYING <input type="checkbox"/> CONTRIBUTING		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) UNK	
22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) UNK (found on Dukeland & Mosher Sts)		22D. TIME OF INJURY (APPROX.) (Month) 4 (Day) 8 (Year) 72 (Hour) 10:50 P.M.	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? Subject found on street engulfed in flames	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/>			
ACTUAL SIGNATURE Peter Lipkovic, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type)		DATE SIGNED 4/9/72	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4/12/72	
24C. NAME OF CEMETERY or CREMATORY Mt. Calvary		24D. LOCATION (City, town, or county) (State) Baltimore Md.	
25A. DATE REC'D BY HEALTH DEPT. APR 14 1972		25B. NAME OF REGISTRAR Robert E. Taylor, R.D.	
25C. FUNERAL DIRECTOR Mary B Law		ADDRESS 802 Madison Ave.	

5-12-1972 - Letter from Office of the Chief Medical Examiner, Peter Lipkovic, M.D.

Assistant Medical Examiner

HRS

K 620

BALTIMORE CITY HEALTH DEPARTMENT

72 03614

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

72 03614

BIRTH NO.

1. NAME OF DECEASED (Type or Print) WILLIAM P. KIRK		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 00 507 McMechen Street		3. DATE PRONOUNCED DEAD Month Day Year Hour April 4, 1972 7:15 P.	
6. SEX Male		7. RACE Negro	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore	
9. DATE OF BIRTH 3-30-14		10. AGE (In years lost birthday) 58	
11. BIRTHPLACE (State or foreign country) Madison Co. Tenn.		12. CITIZEN OF U.S. WHAT COUNTRY? U.S.	
13. FATHER'S NAME Simmon Kirk		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		14B. KIND OF BUSINESS OR INDUSTRY	
15. MOTHER'S MAIDEN NAME Sadie		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) NO	
17. SOCIAL SECURITY NO. 415-14-6370		18. INFORMANT Bledsoe, Funeral Home Jackson Tenn.	
19. 5-7-18 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		CAUSE OF DEATH Fatty liver with early cirrhosis (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) yes (partial)			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> (Partial) and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <i>Ronald N. Kornblum</i> M.D. EXAMINER'S NAME (Type) Ronald N. Kornblum, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 4/5/72			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4/16/72	
24C. NAME of CEMETERY or CREMATORY Mt. Olivet		24D. LOCATION (City, town, or county) (State) Jackson Tenn.	
25A. DATE REC'D BY HEALTH DEPT. APR 14 1972		25B. NAME OF REGISTRAR Robert E. Fisher, M.D.	
25C. FUNERAL DIRECTOR Bledsoe, Funeral Home		ADDRESS Jackson, Tenn.	

1914

RECEIVED

1914

1914

1914

1914



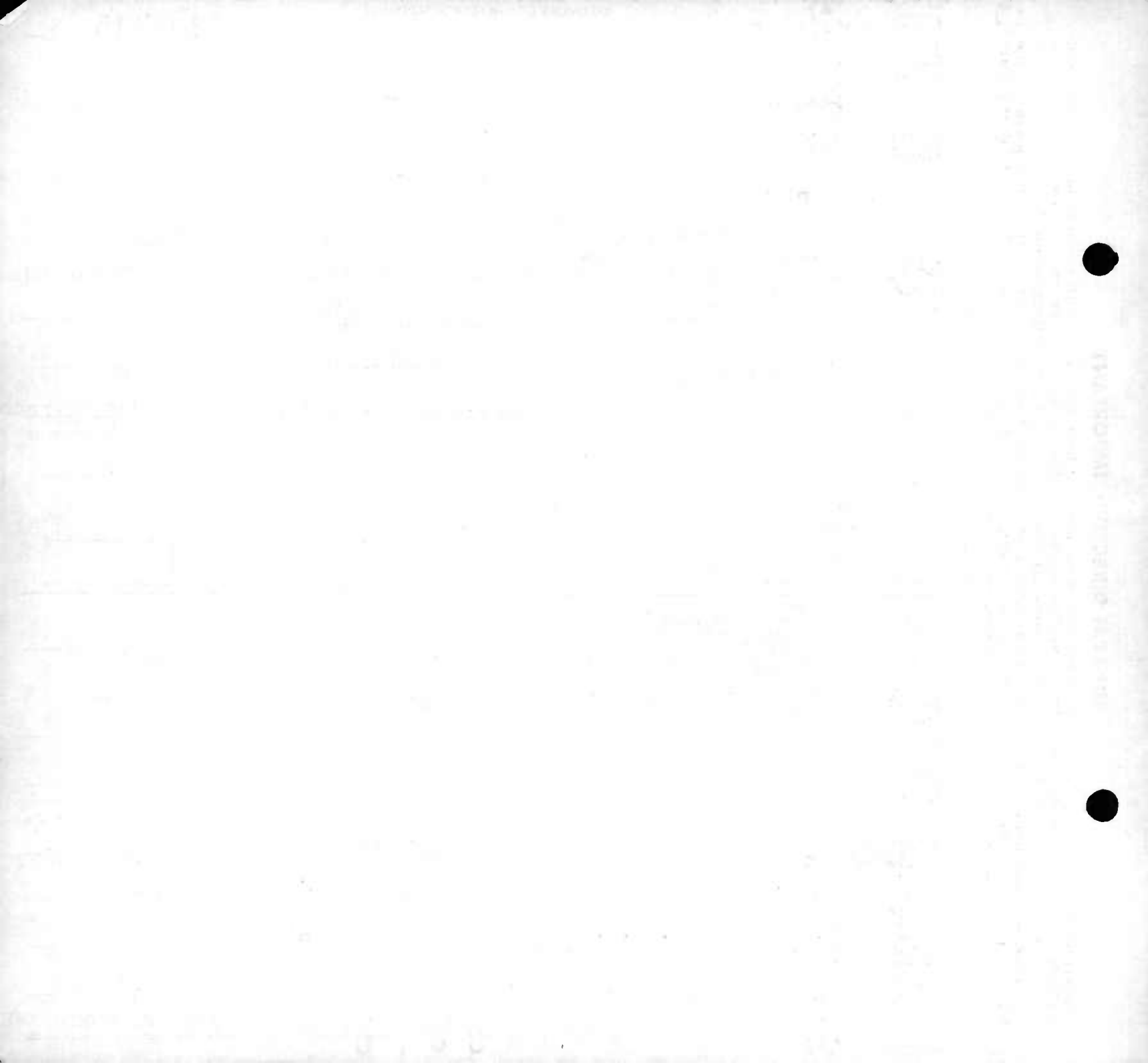
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO. 72 03615

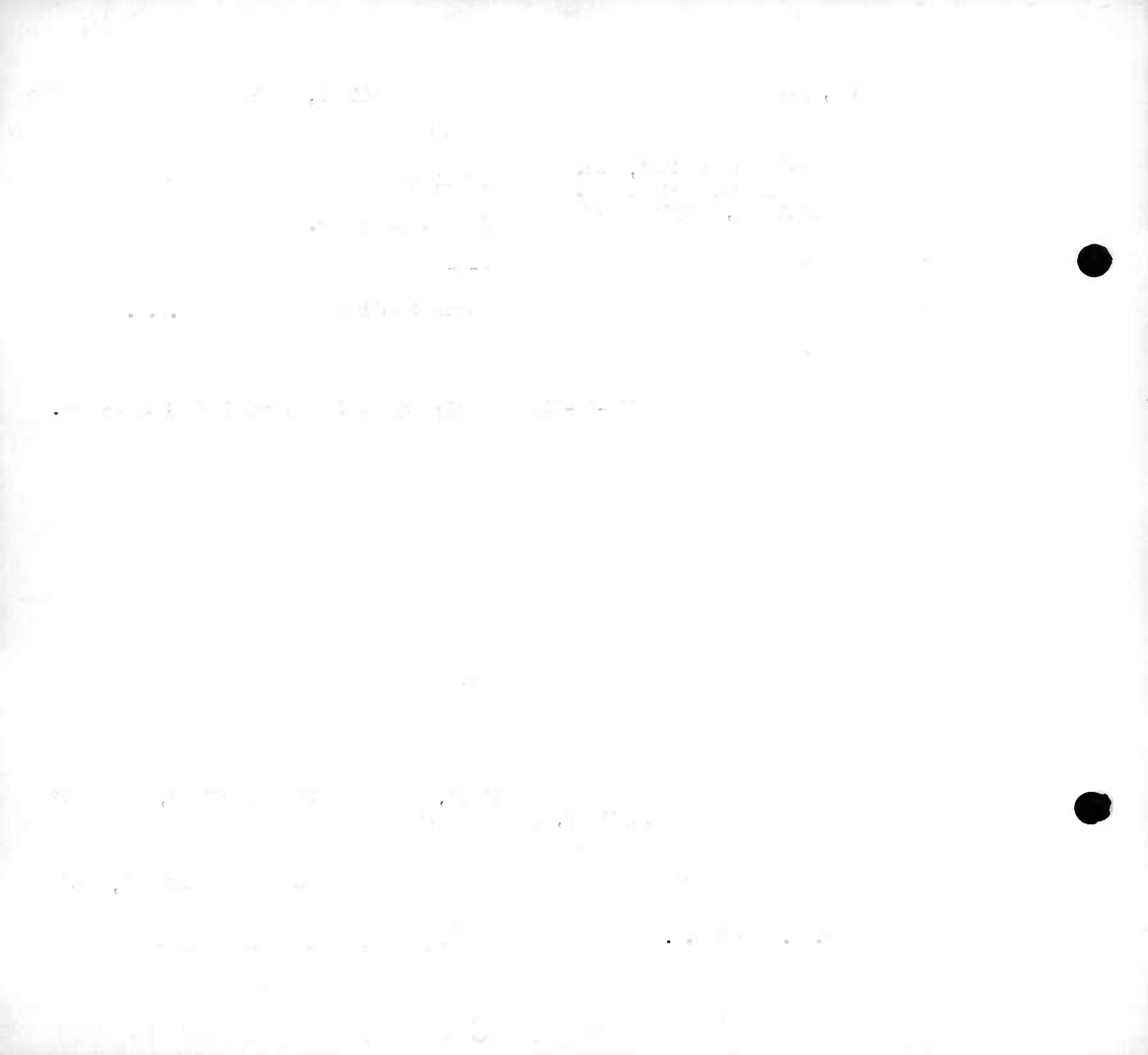
BIRTH NO. <u>72 03615</u>		BALTIMORE CITY HEALTH DEPARTMENT	
1. NAME OF DECEASED (Type or Print) <u>Preston H. Tucker</u>		2. DATE AND HOUR OF DEATH <u>April 12, 1972</u> M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>00 3016 Poplar Terrace</u>		4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>1547</u> C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>3016 Poplar Terrace</u>	
5. SEX <u>Male</u>	6. RACE <u>Negro</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-13-1915</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>mechanic</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Pacel Post</u>	9. AGE (In years last birthday) <u>57</u>
13. FATHER'S NAME <u>Buddy Tucker</u>		11. BIRTHPLACE (State or foreign country) <u>North Carolina</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
16. SOCIAL SECURITY NO. <u>212-07-0593</u>		14. MOTHER'S MAIDEN NAME <u>Trueletta Jefferson</u>	
17. INFORMANT <u>Mrs. Lila L. Tucker</u>		ADDRESS <u>3016 Poplar Terrace</u>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>144X1</u> <u>Radicular recurrent squamous</u> <u>cell carcinoma floor of mouth</u> <u>massive</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs</u>	
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>II</u>			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
19A. DATE OF OPERATION <u>0</u>	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>19</u> to <u>19</u> that (I) (we) lost saw the deceased alive on <u>19</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <u>R. H. Johnson, Jr. M.D.</u>		23B. DATE SIGNED <u>4/12/72</u>	
23C. PHYSICIAN'S NAME (Type) <u>Robert H. Johnson, Jr., M.D.</u>		23D. ADDRESS <u>University Hospital</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>	24B. DATE <u>4-15-72</u>	24C. NAME of CEMETERY or CREMATORY <u>Arbutus Memorial Park</u>	24D. LOCATION (City, town, or county) (State) <u>Baltimore Co., Maryland</u>
25A. DATE REC'D BY HEALTH DEPT. <u>APR 14 1972</u>	25B. NAME OF REGISTRAR <u>E. J. Taylor, M.D.</u>	25C. FUNERAL DIRECTOR <u>NUTTER FUNERAL HOME 3035 W. NORTH AVE</u>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

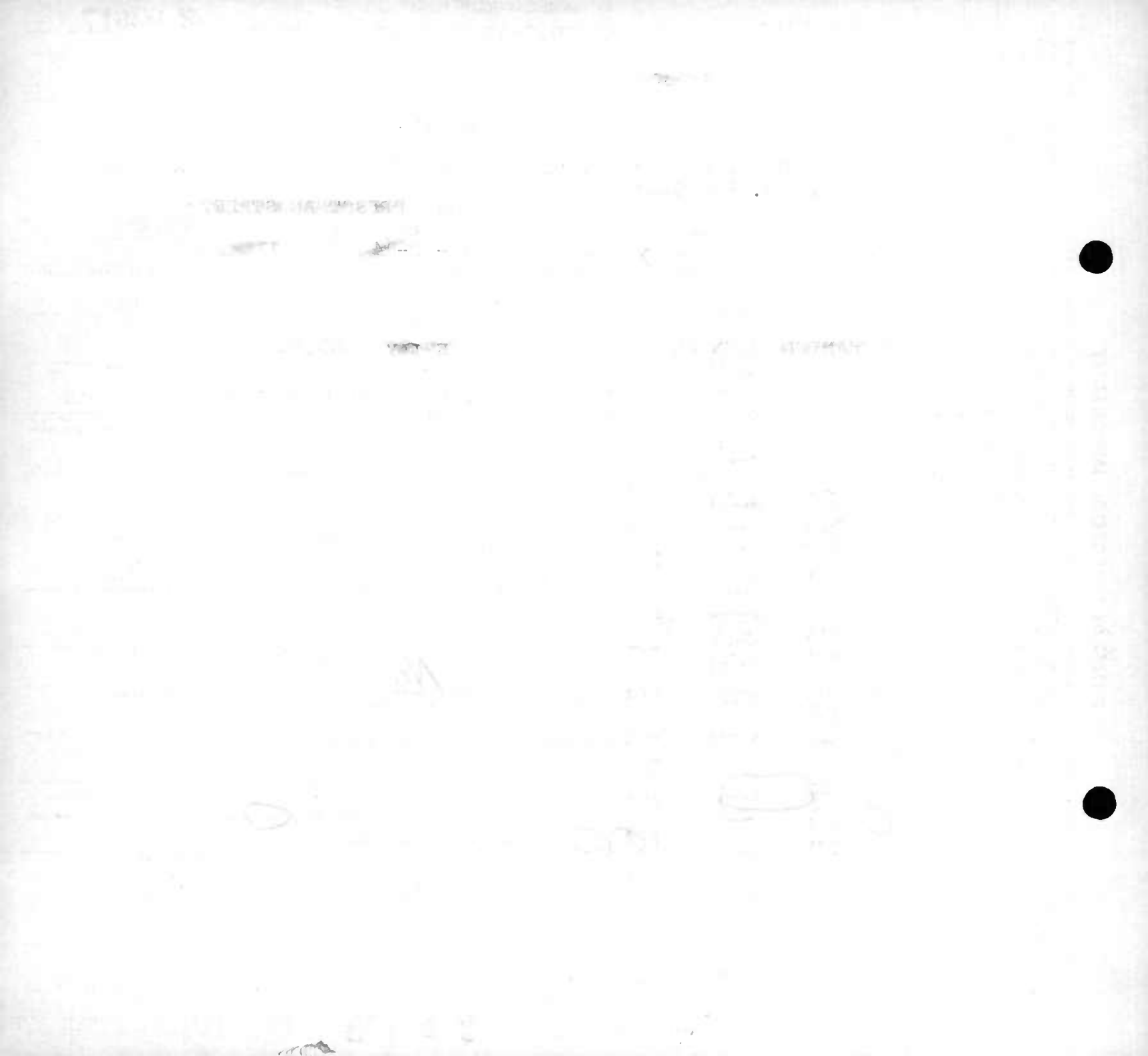
72 03616		BALTIMORE CITY HEALTH DEPARTMENT		72 03616	
CERTIFICATE OF DEATH		REG. NO.			
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		Ford, John W.		April 13, 1972 11am.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION 39 Provident Hospital, Inc. 2600 Liberty Height Ave. Baltimore, Maryland 21215		A. STATE Maryland		B. COUNTY 1512	
		C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER 3911 Cottage Ave.			
5. SEX Male	6. RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-8-00	9. AGE (In years last birthday) 71	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) farmer		10B. KIND OF BUSINESS OR INDUSTRY Farm Industry		11. BIRTHPLACE (State or foreign country) North Carolina	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Charles Ford		14. MOTHER'S MAIDEN NAME Josephine Royal	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 241-42-9381		17. INFORMANT Fannie Bryant (daughter) 3911 Cottage Ave.	
18. 579.31 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE Respiratory Failure DUE TO, OR AS A CONSEQUENCE OF: (B) Pneumonia DUE TO, OR AS A CONSEQUENCE OF: (C) Chronic Obst. Airway Disease Asc'd and Chronic Renal Failure		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 days	
MEDICAL CERTIFICATION					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from April 11, 1972 to April 13, 1972 that (I) (we) last saw the deceased alive on April 13, 1972 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE M. J. Shafi		23B. DATE SIGNED April 14, 1972			
23C. PHYSICIAN'S NAME (Type) M. J. Shafi M.D.		23D. ADDRESS Provident Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4-18-72		24C. NAME OF CEMETERY OR CREMATORY Family Lot	
24D. LOCATION Fayetteville		24E. STATE N. C.			
25A. DATE REC'D BY HEALTH DEPT. APR 14 1972		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR BUSTER FUNERAL HOME 3035 W. NORTH AVE	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>72 03617</u>
BIRTH NO. <u>72 03617</u>		CERTIFICATE OF DEATH		
1. NAME OF DECEASED (Type or Print) <u>HATTIE R. BROWN</u>		2. DATE AND HOUR OF DEATH <u>4-11-72</u> <u>9:45 P.</u> M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <u>33</u> <u>JOHNS HOPKINS HOSPITAL</u> <u>601 N. BROADWAY</u>		A. STATE <u>MARYLAND</u> B. COUNTY <u>1607</u>		
		C. CITY OR TOWN <u>BALTIMORE</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
		E. STREET AND NUMBER <u>2811 PRESSTMAN STREET</u>		
5. SEX <u>FEMALE</u>	6. RACE <u>NEGRO</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-12-94</u>	9. AGE (in years lost birth) <u>77</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>NATHANIEL JOHNSON</u>		
14. MOTHER'S MAIDEN NAME <u>EMILY SANDERS</u>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		
16. SOCIAL SECURITY NO. <u>215-32-6710</u>		17. INFORMANT <u>MR. ALVIN JACKSON 3803 HILTON ROAD</u>		
18. <u>707101</u> CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Septic</u>				<u>10 days</u>
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				
(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Sacral decubiti</u>				<u>2 wks</u>
(B) <u>Being Bedridden</u>				<u>4 mos</u>
(C) <u>Being Bedridden</u>				
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY (Yes or No) <u>No</u>
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from <u>3-30</u> 19 <u>72</u> to <u>4-11</u> 19 <u>72</u> that (I) (we) last saw the deceased alive on <u>4-11</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <u>James Franklin Crim MD</u>		23B. DATE SIGNED <u>4-11-72</u>		
23C. PHYSICIAN'S NAME (Type) <u>James Franklin Crim MD</u>		23D. ADDRESS <u>Johns Hopkins Hospital</u>		
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>4-18-72</u>		24C. NAME of CEMETERY or CREMATORY <u>Church Cemetery</u>
24D. LOCATION <u>White Marsh</u>		24E. LOCATION (City, town, or county) (State) <u>Maryland</u>		
25A. DATE REC'D BY HEALTH DEPT. <u>APR 14 1972</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor, R.D.</u>		25C. FUNERAL DIRECTOR <u>WUTTER FUNERAL HOME 3035 W. NORTH AVE.</u>



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 03618	
E-500 72 03618		CERTIFICATE OF DEATH	
BIRTH NO. <u>72 05026</u>		DATE AND HOUR OF DEATH <u>4-11-72</u> <u>10¹⁰ pm</u> M.	
1. NAME OF DECEASED (Type or Print) <u>ENEY, BABY BOY</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>1203</u>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <u>Church Home and Hospital</u> <u>35</u> IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION		C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER <u>2742 Guilford Ave</u>			
5. SEX <u>Male</u>	6. RACE <u>Caucasian</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-11-72</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY <u>—</u>	9. AGE (In years last birthday) <u>37 min.</u>
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>United States</u>	
13. FATHER'S NAME <u>Eney, Charles A.</u>		14. MOTHER'S MAIDEN NAME <u>Stowe, Linda</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>—</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>C. A. ENEY, BALTIMORE, MD.</u>		ADDRESS <u>2742 GUILFORD AVE.</u>	
18. <u>7-5-9-91</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>Prenatality</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>—</u> DUE TO, OR AS A CONSEQUENCE OF: (C) <u>—</u>	
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>Multiple Congenital Anomalies</u>			
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) <u>YES</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>9:30 pm April 11 1972</u> to <u>10:00 pm April 11 1972</u> that (I) (we) last saw the deceased alive on <u>April 11 1972</u> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <u>P. Cabeling-Borja, M.D.</u>		23B. DATE SIGNED <u>4-11-72</u>	
23C. PHYSICIAN'S NAME (Type) <u>PURITA C. BORJA</u>		23D. ADDRESS <u>CHURCH HOME & HOSPITAL</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>4-14-72</u>	
24C. NAME OF CEMETERY or CREMATORY <u>HIGHLAND</u>		24D. LOCATION (City, town, or county) (State) <u>STREET HARFORD MD.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>APR 14 1972</u>		25B. NAME OF REGISTRAR <u>John H. Harkins</u>	
25C. FUNERAL DIRECTOR <u>John H. Harkins</u>		ADDRESS <u>DELTA, PA.</u>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. <u>72 03619</u>	
M-635 72 03619 BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>Frank Robert Martin</u>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>46 Lutheran Hosp.</u>		2. DATE AND HOUR OF DEATH <u>4-11-72</u> <u>8:35</u> M. 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <u>MD</u> B. COUNTY <u>1606</u> C. CITY OR TOWN <u>BALTO</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>921-ROSEDALE ST</u>	
5. SEX <u>M</u>	6. RACE <u>C</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-15-19</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY <u>Construction</u>	9. AGE (in years last birthday) <u>52</u>
11. BIRTHPLACE (State or foreign country) <u>S. C. Anderson</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William Martin</u>		14. MOTHER'S MAIDEN NAME <u>Maagie Haster</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates at service)		16. SOCIAL SECURITY NO. <u>265-10-1396</u>	17. INFORMANT <u>Mrs. Lillie B. Martin-921-Rosedale St.</u>
18. <u>410.91</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). 19A. DATE OF OPERATION <u>0</u> 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 20A. AUTOPSY? (Yes or No) <u>NO</u> 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner) 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour) 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> 21F. HOW DID INJURY OCCUR? 22. I certify that <u>he</u> (this hospital) attended the deceased from <u>4/10/72</u> 19 to <u>4/11</u> 19 <u>72</u> that <u>we</u> last saw the deceased alive on <u>4/11/72</u> 19 and that in <u>my</u> (our) opinion death occurred on the date and hour and from the causes stated above. <u>He</u> (We) (did) (did not) view the body after death. 23A. SIGNATURE <u>John Lwin</u> 23B. DATE SIGNED 23C. PHYSICIAN'S NAME (Type) <u>SEIN LWIN</u> 23D. ADDRESS <u>LUTHERAN HOSPITAL</u> 24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u> 24B. DATE <u>4-16-72</u> 24C. NAME of CEMETERY or CREMATORY <u>New China Cemetery</u> 24D. LOCATION (City, town, or county) (State) <u>Troy, S.C.</u> 25A. DATE REC'D BY HEALTH DEPT. <u>APR 14 1972</u> 25B. NAME OF REGISTRAR <u>Robert E. Taylor, M.D.</u> 25C. FUNERAL DIRECTOR <u>Robert E. Taylor</u> ADDRESS <u>101-101-101-101</u>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT																			
BIRTH NO. B-260 72 03620					CERTIFICATE OF DEATH					REG. NO. 72 03620									
1. NAME OF DECEASED (Type or Print) Booker Willive FLOYD					2. DATE AND HOUR OF DEATH April 10, 72 1 10 25 P.M.														
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)														
FULL NAME OF HOSPITAL OR INSTITUTION 39 Provident Hosp.					(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)					A. STATE md									
										B. COUNTY Baltimore									
					C. CITY OR TOWN Baltimore					D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
					E. STREET AND NUMBER 1705 N. Calhoun St.														
5. SEX M		6. RACE NN		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH 4-18-14		9. AGE (In years last birthday) 57		If Under 1 Yr. Months: Days: Hours: Min.		If Under 24 Hrs. Min.							
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired					10B. KIND OF BUSINESS OR INDUSTRY					11. BIRTHPLACE (State or foreign country) Va									
										12. CITIZEN OF WHAT COUNTRY? USA									
13. FATHER'S NAME Joe M. Booker					14. MOTHER'S MAIDEN NAME Celia Booker														
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service					16. SOCIAL SECURITY NO. 217-03-7089					17. INFORMANT ADDRESS Mrs. Edith Booker 1705 N. Calhoun Street									
18. 250.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.										CAUSE OF DEATH ASHD, CHF, Myocardial Infarction					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
										(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Pulmonary emboli & thrombophlebitis					(B) DUE TO, OR AS A CONSEQUENCE OF: Diabetes mellitus, Uremia				
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).																			
19A. DATE OF OPERATION					19B. CONDITION FOR WHICH OPERATION WAS PERFORMED					20A. AUTOPSY? (Yes or No)					20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)					21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)					21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)									
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)					21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					21F. HOW DID INJURY OCCUR?									
22. I certify that (I) (the hospital) attended the deceased from March 6 19 72 to April 10 19 72 that (I) (we) last saw the deceased alive on April 10 19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.																			
23A. SIGNATURE V-Chitraplee					Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>					23B. DATE SIGNED April 10, 72									
23C. PHYSICIAN'S NAME (Type) V-Chitraplee					23D. ADDRESS Provident Hosp.														
24A. BURIAL CREMATION, REMOVAL (Specify) Burial					24B. DATE 4-15-72					24C. NAME of CEMETERY or CREMATORY Arbutus Mem. Park					24D. LOCATION (City, town, or county) (State) Baltimore, Maryland				
25A. DATE REC'D BY HEALTH DEPT. APR 14 1972					25B. NAME OF REGISTRAR Phillips					25C. FUNERAL DIRECTOR Arlington S. Phillips					ADDRESS 1727 N. Monroe Street				

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

S-160 BIRTH NO.		72 03621		BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		REG. NO. 72 03621	
1. NAME OF DECEASED (Type or Print) SPARROW, RUTH MAE				2. DATE AND HOUR OF DEATH APRIL 12, 1972 7:35 A.M.					
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) ST. AGNES HOSPITAL 40				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY HOWARD C. CITY OR TOWN D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER 6489 MEADOWRIDGE RD BALTO MD 21227					
5. SEX FEMALE		6. RACE NEGRO		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 06-26-88		9. AGE (In years last birthday) 83 If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE				10B. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? UNITED STATES	
13. FATHER'S NAME HORACE BLACKSTONE				14. MOTHER'S MAIDEN NAME Ella (JACKSON)					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO				16. SOCIAL SECURITY NO. -		17. INFORMANT ADDRESS WILKENS & CATON AVE. BALTO MD 21229 ST. AGNES HOSPITAL RECORD'S -			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., head failure, asphyxia, etc. It means the disease, injury, or complication which caused death.) E8735 Cerebrovascular accident				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Cardiopulmonary failure Extensive 2°-3° Burns 60% (B) INTERMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Stroke (C) UNDERLYING CONDITION LAST. N.D. CHIEF MED. EXAM.				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 days 5 days	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).									
19A. DATE OF OPERATION 4-8-72		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Tracheotomy		20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Safely seen.			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input checked="" type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office, bldg., etc.) HOME		21C. WHERE DID INJURY OCCUR? FIRE CAUGHT HER CLOTHES		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) 4-7-72 7 pm			
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? FIRE CAUGHT HER CLOTHES		22. I certify that (X) (this hospital) attended the deceased from APRIL 7 1972 to APRIL 12 1972, that (X) (we) last saw the deceased alive on APRIL 12 1972 and that in (XX) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (did not) view the body after death.					
23A. SIGNATURE [Signature] DEGREE				23B. DATE SIGNED 4-12-72		23C. PHYSICIAN'S NAME (Type) BAMROONG LERD BOON MD DEGREE		23D. ADDRESS ST AGNES HOSPITAL BALTO MD 21229	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4-16-72		24C. NAME OF CEMETERY or CREMATORY St. Stephens Cem.		24D. LOCATION (City, town, or county) (State) Elkridge, Maryland		25A. DATE REC'D BY HEALTH DEPT. APR 14 1972	
25B. NAME OF REGISTRAR Robert E. Bailey, Jr.		25C. FUNERAL DIRECTOR Arlington S. Phillips		25D. ADDRESS 1727 N. Monroe Street					

15000 50

15000 50

2532 A

APRIL 12, 1972

NAME RUTH

SPARROW

NO 20 XX

ST. JAMES HOSPITAL

FILED NO 21537

05-25-88

XX

FEW LE WARD

UNITED STATES

MARYLAND

HOESENITE

ETI (JACKSON)

NOBACE BLACKSTONE

WILKINS & CATON AVE. BALTO MD 21229
ST. JAMES HOSPITAL RECORDS -

NO

72 APRIL 12

APRIL 7

APRIL 12

N

XXXX

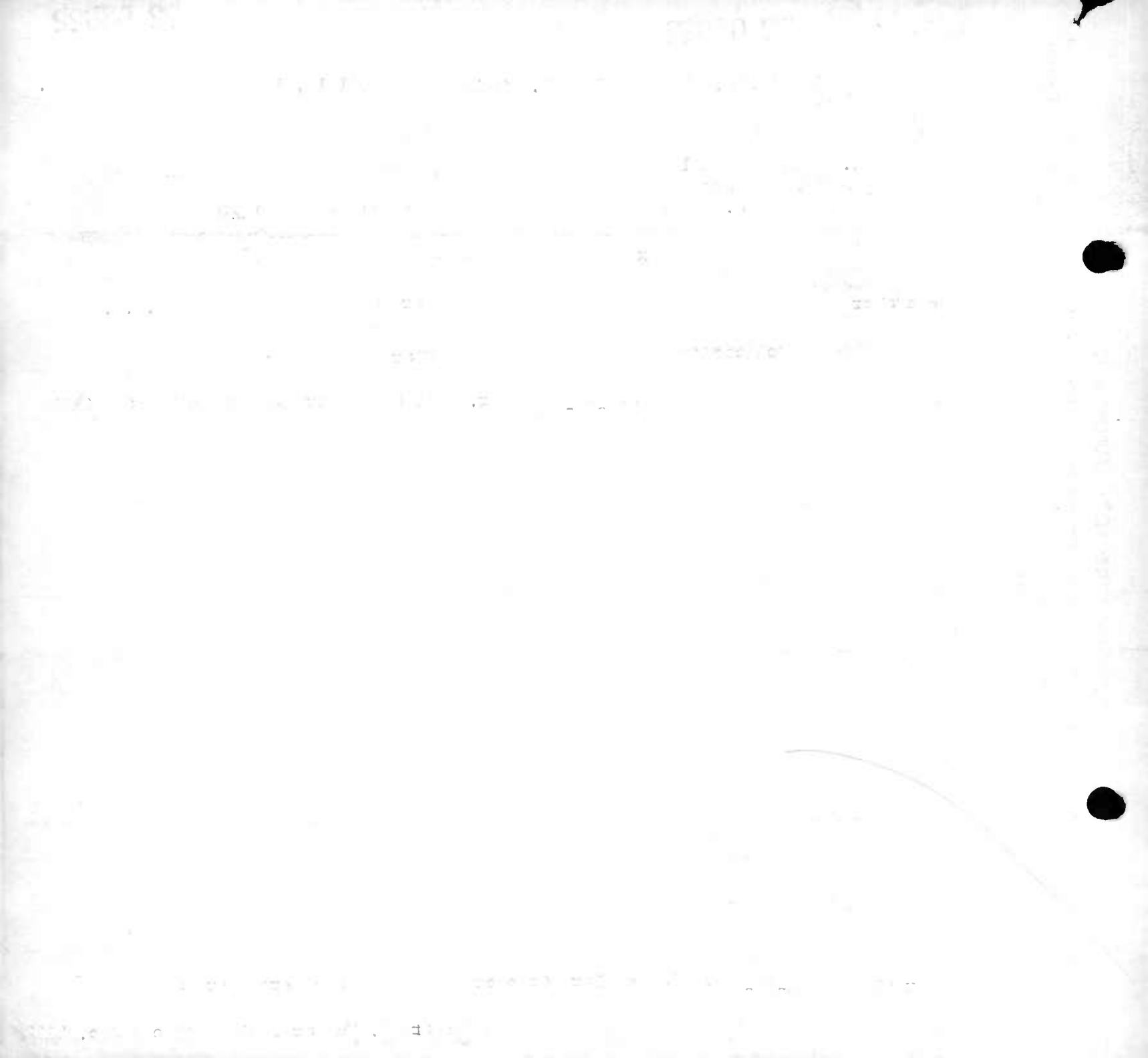
ST. JAMES HOSPITAL BALTO MD 21229

SPARROW LEWIS MD

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. C-600				BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 03622			
1. NAME OF DECEASED (Type or Print) XXXXXXXXXXXXXXXX MADOLYN B. CARR				2. DATE AND HOUR OF DEATH April 15, 1972 2:00 A. M.							
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland				B. COUNTY			
FULL NAME OF HOSPITAL OR INSTITUTION 40 St. Agnes Hospital 900 Caton Avenue Baltimore, Md. 21229				C. CITY OR TOWN Baltimore				D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
E. STREET AND NUMBER 909 Calwell Road #21229											
5. SEX F	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-22-79	9. AGE in years (last birthday) 92	If Under 1 Yr. Months: Days: Hours: Min.		If Under 24 Hrs. Min.				
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker				10B. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country) Maryland			
12. CITIZEN OF WHAT COUNTRY? U.S.A.				13. FATHER'S NAME Milton Belleson				14. MOTHER'S MAIDEN NAME Clarissa Willis			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. 214-16-5830				17. INFORMANT ADDRESS Mr. William Miller, 909 Calwell Road 21229			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 412.4 I CEREBROVASCULAR ACCIDENT				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) Severe ASCVD DUE TO, OR AS A CONSEQUENCE OF:							
(C)											
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).											
19A. DATE OF OPERATION				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED				20A. AUTOPSY? (Yes or No)			
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?											
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 19 to 19 that (I) (we) last saw the deceased alive on 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.											
23A. SIGNATURE Donato A. Vargas Jr. M.D. DEGREE								23B. DATE SIGNED 4-15-72			
23C. PHYSICIAN'S NAME (Type) DONATO A. VARGAS JR. M.D. DEGREE								23D. ADDRESS			
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial				24B. DATE 4-17-1972				24C. NAME of CEMETERY or CREMATORY Loudon Park Cemetery			
24D. LOCATION (City, town, or county) (State) Baltimore, Maryland											
25A. DATE REC'D BY HEALTH DEPT. APR 17 1972				25B. NAME OF REGISTRAR R. E. Johnson				25C. FUNERAL DIRECTOR ADDRESS Howard H. Hubbard, 4107 Wilkens Ave. 21229			



J-525

72 03623

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

72 03623

BIRTH NO.

REG. NO.

1. NAME OF DECEASED (Type or Print) Weldon P. Johnson		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month 4 Day 11 Year 72	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 1617 St. Paul St.		3. DATE PRONOUNCED DEAD Month 4 Day 11 Year 72 5:25 p. M.	
5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Md. B. COUNTY 1205			
6. SEX male	7. RACE White	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH Oct. 17, 1910		10. AGE (In years last birthday) 61	
11. BIRTHPLACE (State or foreign country) West Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Vernon A. Johnson		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Welder	
15. MOTHER'S MAIDEN NAME Virginia Bogus		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No	
17. SOCIAL SECURITY NO. 235-05-1539		18. INFORMANT Box 109 RR # 7 Mr. Charles A. Johnson Eagle Hill Rd. Pasadena	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) No			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?			
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?			
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE: Peter Lipkovic, M.D. EXAMINER'S NAME (Type) DATE SIGNED: 4/12/72			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4/14/72	
24C. NAME OF CEMETERY OR CREMATORY Belair Memorial Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore Maryland	
25A. DATE REC'D BY HEALTH DEPT. APR 17 1972		25B. NAME OF REGISTRAR Robert E. Farber, M.D.	
25C. FUNERAL DIRECTOR Leonard J. Buck Inc.		25D. ADDRESS 5305 Harford Rd. 21214	

75 0000

75 0000

75 0000

X

X

Oct. 15, 1970

Oct. 15, 1970

Vermon A. Johnson

1970

Vermon A. Johnson

Vermon A. Johnson

Vermon A. Johnson

Box 180

T. Charles A. Johnson

Box

Vermon A. Johnson

Vermon A. Johnson

11/1/72

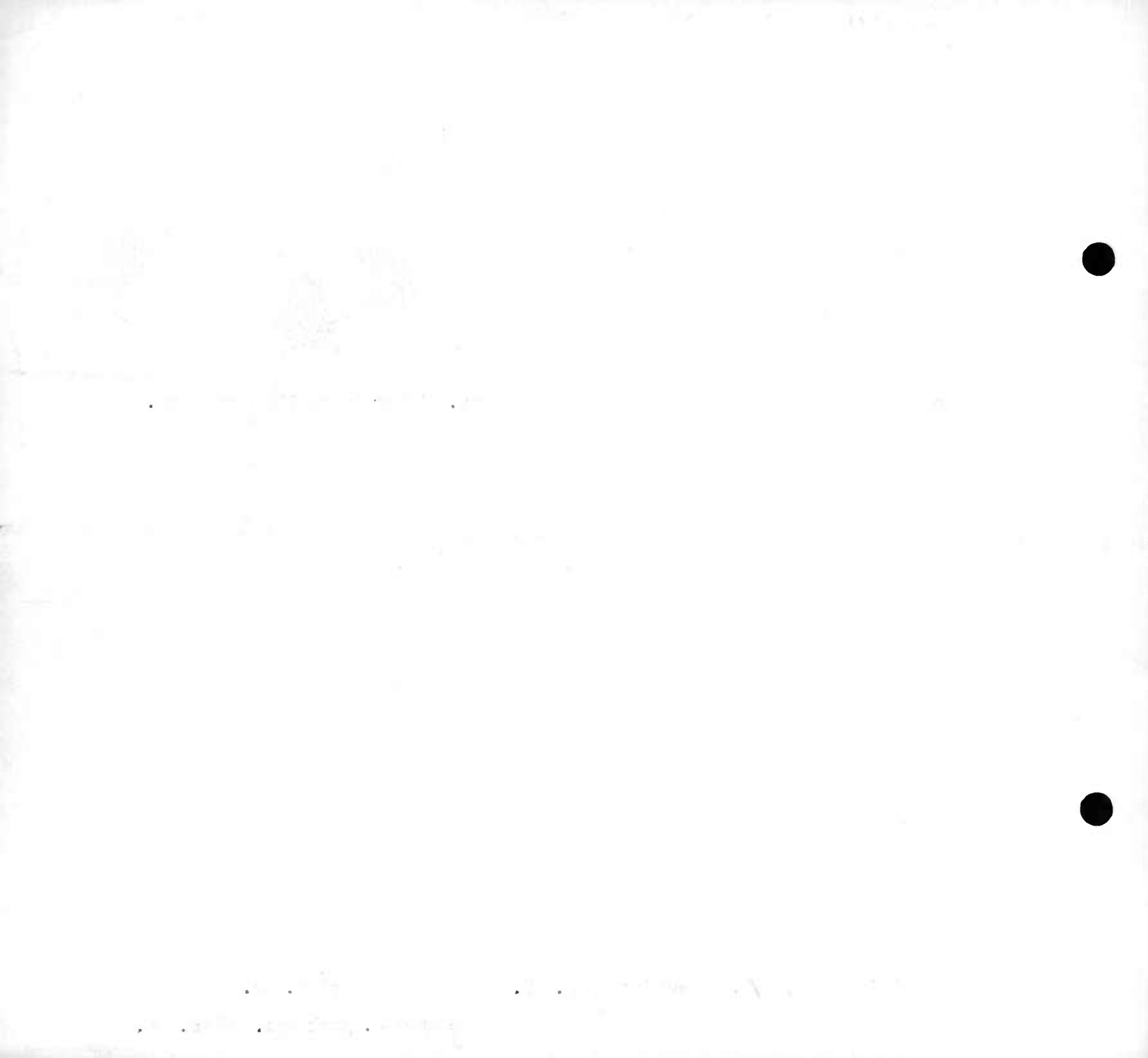
Vermon A. Johnson

Vermon A. Johnson

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Baltimore City Health Department CERTIFICATE OF DEATH				REG. NO. <u>72 03624</u>	
7-460 72 03624 BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>JANE FLOHR</u>		2. DATE AND HOUR OF DEATH <u>4/13/72</u> <u>5:25 A.M.</u>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>CHURCH HOME & HOSPITAL</u>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MD.</u> B. COUNTY <u>602</u> C. CITY OR TOWN <u>BALTO.</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>132 N. Milton Ave.</u>		
5. SEX <u>F</u>	6. RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>07-03-90</u>	9. AGE (in years last birthday) <u>81</u>	10. Under 1 Mo. <input type="checkbox"/> 1 Yr. <input type="checkbox"/> 24 Hrs. <input type="checkbox"/> Min. <input type="checkbox"/>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>			11. BIRTHPLACE (State or foreign country) <u>MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>THOMAS Du Vall</u>			14. MOTHER'S MAIDEN NAME <u>VICTORIA WARFIELD</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u>			16. SOCIAL SECURITY NO. <u>213-98-825</u>		17. INFORMANT ADDRESS <u>Mrs. Wilbur Perry 113 Burke Ave.</u>
18. <u>4/12.3 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <u>Ventricular Fibrillation</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>ASHD, CHF, Digitalis</u> <u>Toxicity</u>			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) <u>ASHD, CHF, Digitalis</u> (C) <u>Toxicity</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>minutes</u> <u>undetermined</u>		
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>YES</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <u>4/12</u> (this hospital) attended the deceased from <u>4/12</u> 19 <u>72</u> to <u>4/13</u> 19 <u>72</u> that <u>we</u> last saw the deceased alive on <u>4/13</u> 19 <u>72</u> and that <u>in</u> (our) opinion death occurred on the date and hour and from the causes stated above. <u>we</u> (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Wilmara go, M.D.</u>				23B. DATE SIGNED <u>4/13/72</u>	
23C. PHYSICIAN'S NAME (Type) <u>WILMA B. MANIAGO M.D.</u>				23D. ADDRESS <u>CHURCH HOME & HOSPITAL</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>4/15/72</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Moreland Mem. Pk.</u>	
24D. LOCATION (City, town, or county) (State) <u>Balto. Md.</u>		25A. DATE REC'D BY HEALTH DEPT. <u>APR 17 1972</u>			
25B. NAME OF REGISTRAR <u>Robert J. ...</u>		25C. FUNERAL DIRECTOR ADDRESS <u>Leonard J. Buck Inc. Balto. Md.</u>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 03625	
8-200 72 03625		BIRTH NO.			
1. NAME OF DECEASED (Type or Print) <u>PETER SAWICKI</u>			2. DATE AND HOUR OF DEATH <u>4-13-72</u> <u>11:10 A.M.</u>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institutions residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <u>00 1401 FILBERT ST</u>			A. STATE <u>MD</u> B. COUNTY <u>2505</u>		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			C. CITY OR TOWN <u>BALTIMORE</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER <u>1401 FILBERT ST.</u>		
5. SEX <u>M</u>	6. RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-18-91</u>	9. AGE (In years last birthday) <u>80</u>	10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CAR REPAIR</u>			10B. KIND OF BUSINESS OR INDUSTRY <u>B. & O.</u>		11. BIRTHPLACE (State or foreign country) <u>POLAND</u>
12. CITIZEN OF WHAT COUNTRY <u>POLAND</u>			13. FATHER'S NAME <u>STEVEN</u>		
14. MOTHER'S MAIDEN NAME <u>?</u>			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		
16. SOCIAL SECURITY NO. <u>245-01-2621</u>			17. INFORMANT <u>DAUGHTER</u>		
18. <u>570.01</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc., it means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>II</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Pneumonia, secondary</u> (B) DUE TO, OR AS A CONSEQUENCE OF: <u>Chronic Bronchitis</u> (C) <u>Pulmonary</u>		
19A. DATE OF OPERATION <u>0</u>			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		
20A. AUTOPSY? (Yes or No)			20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from <u>2-26</u> 19 <u>72</u> to <u>4-12</u> 19 <u>72</u> that (I) (we) last saw the deceased alive on <u>4-12-72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Henry G. Summers</u>			23B. DATE SIGNED <u>4.14.72</u>		
23C. PHYSICIAN'S NAME (Type) <u>H. G. Summers MD</u>			23D. ADDRESS <u>1101 Oakwood Ave.</u>		
24A. BURIAL OR CREMATION, REMOVAL (Specify) <u>BURIAL</u>			24B. DATE <u>3-17-72</u>		
24C. NAME OF CEMETERY OR CREMATORY <u>HOLY CROSS</u>			24D. LOCATION (City, town, or county) (State) <u>RITCHIE HWY. BALTO. MD</u>		
25A. DATE REC'D BY HEALTH DEPT. <u>APR 17 1972</u>			25B. NAME OF REGISTRAR <u>Robert E. Jaber, R.D.</u>		
25C. FUNERAL DIRECTOR <u>BALAN</u>			25D. ADDRESS <u>4200 PENNINGTON AVE 21246</u>		



N-256

BALTIMORE CITY HEALTH DEPARTMENT
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

72 03626

BIRTH NO.

REG. NO.

1. NAME OF DECEASED (Type or Print) Mary Newcomer		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month 4 Day 12 Year 72		Hour M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 00 3649 Chestnut Avenue		3. DATE PRONOUNCED DEAD Month 4 Day 12 Year 72		Hour 11:00 a. M.	
5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY 1307		6. SEX female		7. RACE White	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Balto.		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
9. DATE OF BIRTH 5 Sept. 1881		10. AGE (In years last birthday) 90		E. STREET AND NUMBER 3649 Chestnut Avenue	
11. BIRTHPLACE (State or foreign country) West Virginia		12. CITIZEN OF WHAT COUNTRY? U S A		13. FATHER'S NAME Peter Andrew Lambert	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cotton Mill		14B. KIND OF BUSINESS OR INDUSTRY		15. MOTHER'S MAIDEN NAME Mary Elizabeth -	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		17. SOCIAL SECURITY NO. 215 10 5916D		18. INFORMANT Shirley E. Otten	
19. 412.4		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)		Arteriosclerotic cardiovascular disease			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
		(B) DUE TO, OR AS A CONSEQUENCE OF:			
		(C) DUE TO, OR AS A CONSEQUENCE OF:			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) no	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (if in Baltimore City, give exact location) INJURY OCCUR?	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE: Peter Lipkovic, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) DATE SIGNED 4/12/72 ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 14 April 72		24C. NAME OF CEMETERY or CREMATORY Lorraine Park Cemetery	
24D. LOCATION (City, town, or county) Baltimore, Maryland		24E. DATE REC'D BY HEALTH DEPT. APR 17 1972		24F. NAME OF REGISTRAR Robert E. Walker, M.D.	
24G. FUNERAL DIRECTOR Burge Funeral Home		24H. ADDRESS Balto. Md. 21211		24I. DATE SIGNED 4/12/72	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				CERTIFICATE OF DEATH		REG. NO. <u>72 03627</u>	
1. NAME OF DECEASED (Type or Print) <u>LOUIS VICTOR KLAUVENS</u>				2. DATE AND HOUR OF DEATH <u>4/13/72</u> <u>1.25 A.M.</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>CHURCH HOME Y HOSPITAL</u> <u>35</u>				4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE <u>MARYLAND (BALTIMORE)</u> 5300 C. CITY OR TOWN <u>BALTIMORE</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>3520 LANGREHR Road 21207</u>			
5. SEX <u>Male</u>	6. RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11/11/88</u>	9. AGE (in years last birthday) <u>83 year</u>	10. CITIZEN OF WHAT COUNTRY? <u>AFR.</u>		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>TAILOR</u>			10B. KIND OF BUSINESS OR INDUSTRY <u>VEST CONTRACTOR</u> <u>SELF EMPLOYED</u>		11. BIRTHPLACE (State or foreign country) <u>RUSSIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>AFR.</u>
13. FATHER'S NAME <u>ABRAHAM KLAUVENS</u>			14. MOTHER'S MAIDEN NAME <u>LENA ?</u>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service <u>NO</u>		16. SOCIAL SECURITY NO. <u>218 32 9751</u>	17. INFORMANT ADDRESS <u>MRS. HILDA GREENBERG, 4514 DRESDEN RD. #21207</u>				
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>154.11</u> <u>Pneumonia Pulmonary Insufficiency</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Ca of Rectum with Peric. - Unknown</u> <u>Liver Metastasis, Arteriosclerosis - 35 years.</u> <u>Emphysema, Heart Failure - unknown</u>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>6 days</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION <u>3/30/72</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>rectal bleeding</u>		20A. AUTOPSY (Yes or No) <u>NO</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (if in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>3/29/1972</u> to <u>4/13/1972</u> that (I) (we) last saw the deceased alive on <u>4/12/1972</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
23A. SIGNATURE <u>Nabih Sadu</u> M.D. DEGREE				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>4/13/72</u>	
23C. PHYSICIAN'S NAME (Type) <u>MASON KNOX III</u> DEGREE				23D. ADDRESS			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>4-14-72</u>		24C. NAME of CEMETERY or CREMATORY <u>BETH HAMEDROSH HAGODOL</u>		24D. LOCATION (City, town, or county) (State) <u>ROSEDALE, MARYLAND</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>APR 17 1972</u>		25B. NAME OF REGISTRAR <u>Robert J. Kelly</u>		25C. FUNERAL DIRECTOR ADDRESS <u>SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD</u>			

WEST CENTRAL
SELF-EMPLOYED

MEMBER ELEVENTH

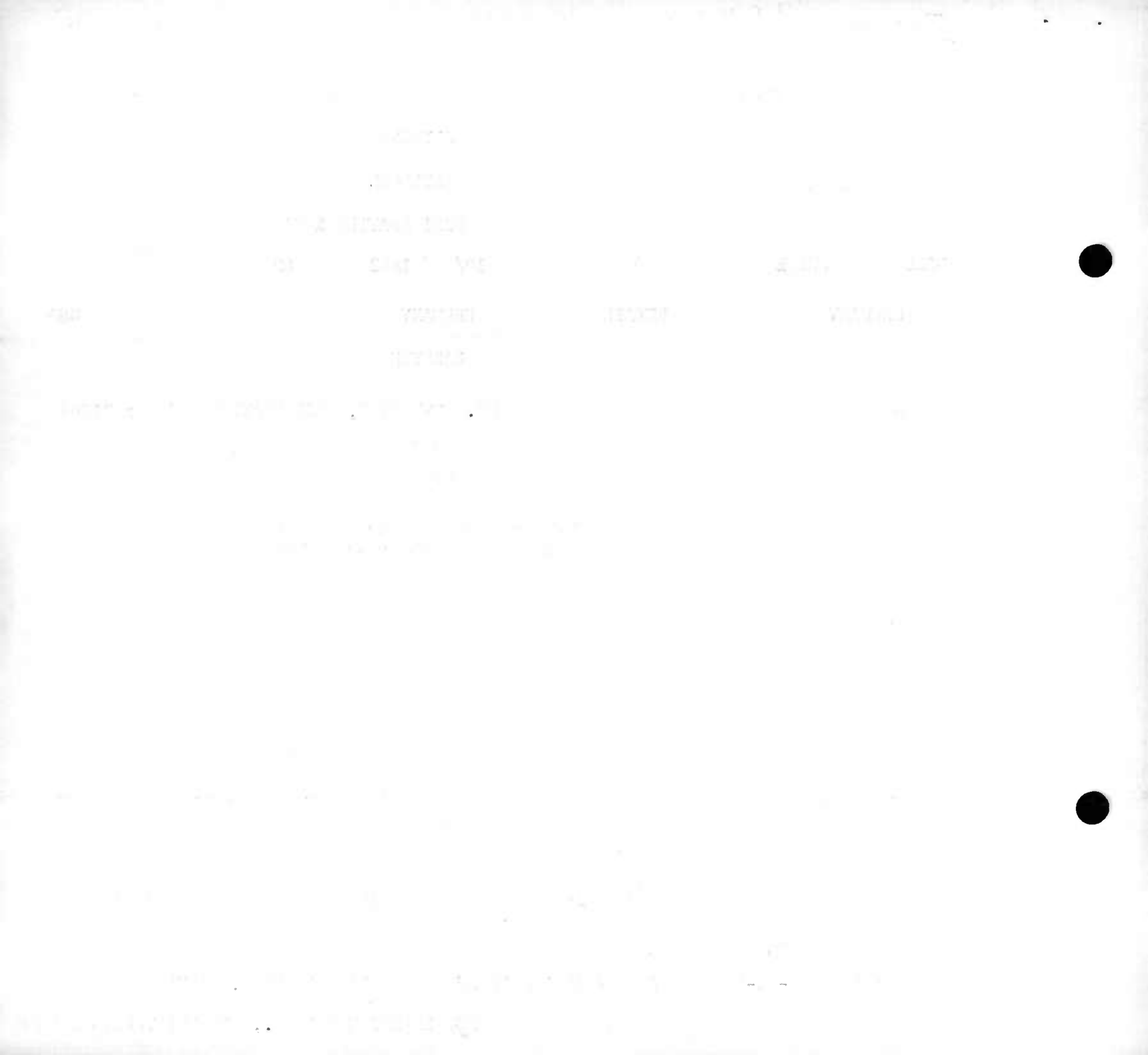
1954

THE UNIVERSITY OF CALIFORNIA

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. 72 03628
BIRTH NO. Z-500		1. NAME OF DECEASED (Type or Print) Sigmund Zion		
2. DATE AND HOUR OF DEATH 4-13-1972 5:20 P. M.				
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD 91 Levindale		4. USUAL RESIDENCE (Where deceased lived, if institutions residence before admission) A. STATE MARYLAND B. COUNTY BALTO		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Levindale		C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>
5. SEX MALE		6. RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MERCHANT		10B. KIND OF BUSINESS OR INDUSTRY RETAIL		8. DATE OF BIRTH 10 / / 1882 9. AGE (In years last birthday) 89
11. BIRTHPLACE (State or foreign country) GERMANY		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME BABETTE		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS MR. KURT ZION, 8251 BRATTLE ROAD #2 21208
18. CAUSE OF DEATH 136 X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Probable intra-abdominal ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. (A) IMMEDIATE CAUSE infection of unknown nature DUE TO, OR AS A CONSEQUENCE OF: (case reported to State Department of Health as communicable disease) (B) infectious communicable disease DUE TO, OR AS A CONSEQUENCE OF: (C) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 month				
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from 6-1 19 71 to 4-13 1972 that (X) (we) last saw the deceased alive on 4-13 19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (Yes) (did) (did not) view the body after death.				
23A. SIGNATURE <i>Theodore R. Reiff</i>		23B. DATE SIGNED 4-14-1972		23C. PHYSICIAN'S NAME (Type) Theodore R. Reiff MD
23D. ADDRESS DEGREE		24. BURIAL CREMATION, 24B. DATE REMOVAL (Specify) BURIAL 4-14-72		
24C. NAME of CEMETERY or CREMATORY CHEVRA AHAVAS CHESSED		24D. LOCATION (City, town, or county) (State) RANDALLSTOWN, MARYLAND		
25A. DATE REC'D BY HEALTH DEPT. APR 17 1972		25B. NAME OF REGISTRAR Robert E. Fisher, M.D.		25C. FUNERAL DIRECTOR ADDRESS SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT						REG. NO. <u>72 03629</u>
<div style="display: flex; justify-content: space-between;"> 7-500 72 03629 CERTIFICATE OF DEATH </div>						
BIRTH NO. <u>72 03629</u>		1. NAME OF DECEASED (Type or Print) <u>Bentho 2102</u>		2. DATE AND HOUR OF DEATH <u>4/12/72</u> <u>10:30 P.M.</u>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <u>SINAI HOSPITAL</u>			A. STATE <u>MARYLAND</u>			
			B. COUNTY <u>BALTO</u>			
IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION			C. CITY OR TOWN <u>BALTIMORE</u>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
			E. STREET AND NUMBER <u>8251 BRATTLE ROAD #21208</u>			
5. SEX <u>FEMALE</u>	6. RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <u>90</u>	9. AGE in years (last birthday)	10. Under 1 Yr. Months: Days: Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>HOUSEWIFE</u>		<u>AT HOME</u>	<u>GERMANY</u>		<u>USA</u>	
13. FATHER'S NAME <u>BERNARD VEIS</u>			14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS			
<u>NO</u>			<u>MR. KURT ZION, 8251 BRATTLE ROAD #21208</u>			
18. <u>553.8 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Sigmoid Obstruction</u>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1-2 days</u>			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>? internal hernia</u>			
			(B) DUE TO, OR AS A CONSEQUENCE OF: <u>ASCUD</u>			
			(C) <u>pre.</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).						
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		
<u>0</u>				<u>NO</u>		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indicate medical examined)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
<input type="checkbox"/>						
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?		
22. I certify that <u>4/12</u> (this hospital) attended the deceased from <u>4/12</u> 19 <u>72</u> to <u>4/12</u> 19 <u>72</u> that <u>4/12</u> (we) last saw the deceased alive on <u>4/12</u> 19 <u>72</u> and that in <u>my</u> (our) opinion death occurred on the date and hour and from the causes stated above. <u>4/12</u> (We) (did) (did not) view the body after death.						
23A. SIGNATURE <u>Robert H. Guy Jr.</u>			23B. DATE SIGNED <u>4/12/72</u>			
23C. PHYSICIAN'S NAME (Type)			23D. ADDRESS			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY		
<u>BURIAL</u>		<u>4-14-72</u>		<u>CHEVRA AHAVASH CHESSED</u>		
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS		
<u>APR 17 1972</u>		<u>Robert E. Guy Jr.</u>		<u>SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD</u>		

RS. 17

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

7

RECEIVED

RECEIVED

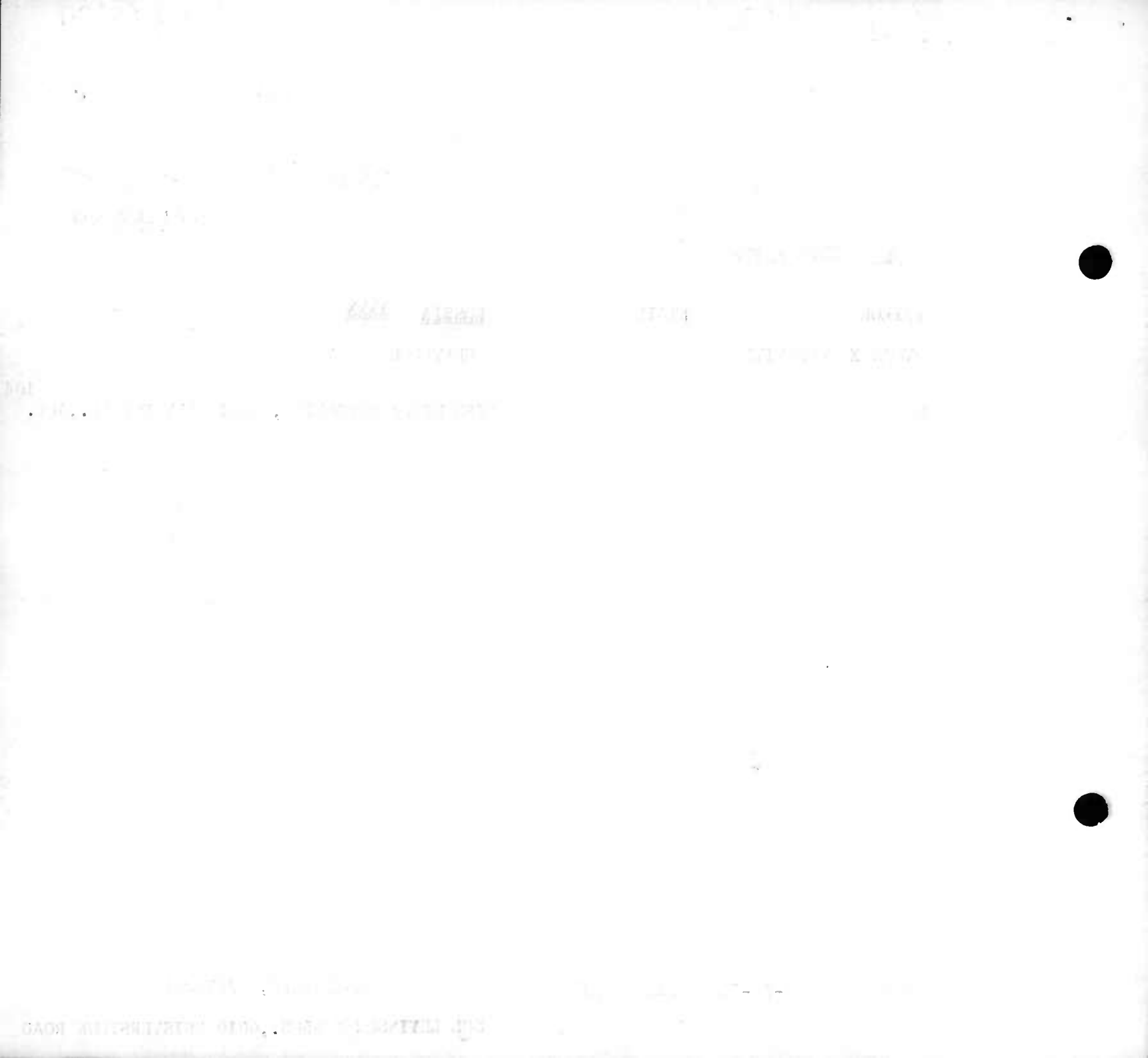
RECEIVED

RECEIVED

RECEIVED

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

M-121 72 03630		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		72 03630
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH
		MOFSOVITZ, Louis		4/13/72 6:40 P.M.
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION 42 Sinai Hospital of Baltimore		A. STATE Maryland		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		B. COUNTY Baltimore		
		C. CITY OR TOWN RANDELLSTOWN		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
		E. STREET AND NUMBER 8601 GREY FOX RD.; RANDELLSTOWN		
5. SEX MALE	6. RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/17/1985	9. AGE (In years last birthday) 86
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) TAILOR		10B. KIND OF BUSINESS OR INDUSTRY RETAIL		11. BIRTHPLACE (State or foreign country) RUSSIA
13. FATHER'S NAME HYMAN M MOFSOVITZ		14. MOTHER'S MAIDEN NAME GERTRUDE ?		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO.		17. INFORMANT MISS HILDA MOFSOVITZ, 8601 GREY FOX RD., APT. 104
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH 163.11 + 250.9 (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). DIABETES, CHRONIC RENAL DISEASE		CAUSE OF DEATH (A) IMMEDIATE CAUSE TERMINAL MEDIASTINAL CANCER ONE YEAR DUE TO, OR AS A CONSEQUENCE OF: (B) CHRONIC OBST. LUNG DISEASE DUE TO, OR AS A CONSEQUENCE OF: (C) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH ONE YEAR		
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from MARCH 8 19 72 to APRIL 13 19 72 that (I) (we) last saw the deceased alive on APRIL 13 19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE Anacleto T. Ordinario, Jr. M.D.		23B. DATE SIGNED 4-13-72		
23C. PHYSICIAN'S NAME (Type) ANACLETO T. ORDINARIO, Jr. M.D.		23D. ADDRESS Sinai Hosp. of Balto.		
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL	24B. DATE 4-14-72	24C. NAME of CEMETERY or CREMATORY AITZ CHAIM	24D. LOCATION (City, town, or county) (State) BALTIMORE, MARYLAND	
25A. DATE REC'D BY HEALTH DEPT. APR 17 1972		25B. NAME OF REGISTRAR Reed 397.2 0 0 0		25C. FUNERAL DIRECTOR SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 03631	
CERTIFICATE OF DEATH					
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
ESTHER GORDON		April 13 1972		7:30 PM.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION			A. STATE		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			B. COUNTY		
X 3416 OLYMPIA AVENUE			MARYLAND		
			C. CITY OR TOWN		D. INSIDE CITY LIMITS?
			BALTIMORE		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER		
			3416 OLYMPIA AVENUE #21215		
5. SEX	6. RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
FEMALE	WHITE	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	JUNE 7, 1918	53	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
BOOKKEEPER		MORRIS LIQUORS		WEST VIRGINIA	
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
MORRIS BERNSTEIN			ANNA POLLACK		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
NO		215-16-0378		MR. JACK GORDON, 3416 OLYMPIA AVE. #21215	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH			CAUSE OF DEATH		
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		
ANTECEDENT CAUSES			DUE TO, OR AS A CONSEQUENCE OF:		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(B) DUE TO, OR AS A CONSEQUENCE OF:		
			(C) DUE TO, OR AS A CONSEQUENCE OF:		
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (1) (this hospital) attended the deceased from April 2 1972 to April 13 1972, that (1) (we) last saw the deceased alive on April 2 1972 and that in my (aur) opinion death occurred on the date and hour and from the causes stated above, (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
David I. Miller M.D.				April 13 1972	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
DAVID I. MILLER				9115 REISTERSTOWN ROAD	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
BURIAL		4-14-72		CHIZUK AMUNO (ARLINGTON)	
				BALTIMORE, MARYLAND	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
APR 17 1972		Robert E. Johnson		SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD	

RECEIVED
JAN 10 1964
U.S. AIR FORCE

TO: SAC, NEW YORK

FROM: SAC, NEW YORK

SUBJECT: [illegible]

RE: [illegible]

U.S. AIR FORCE

NEW YORK

FOR INFORMATION & RECORD, NEW YORK

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>72 03632</u>	
G-431				72 03632	
BIRTH NO. <u>72 03632</u>				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <u>MORRIS Goldberg</u>			2. DATE AND HOUR OF DEATH <u>4/13/72</u> <u>8:10 P</u> M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>2831</u>		
FULL NAME OF HOSPITAL OR INSTITUTION <u>Jewish Convalescent Home</u> <u>90 4601 PAUL MAIL RD.</u>			C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			E. STREET AND NUMBER <u>4108 ROGERS AVE.</u>		
5. SEX <u>Male</u>	6. RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5/18/86</u>	9. AGE (In years last birthday) <u>85</u>	If Under 1 Yr. Months: Days: Hours: Min. <u>10</u> <u>25</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED EMPLOYEE</u>			10B. KIND OF BUSINESS OR INDUSTRY <u>Steel CO.</u>		11. BIRTHPLACE (State or foreign country) <u>Russia</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			13. FATHER'S NAME <u>Herchel Goldberg</u>		
14. MOTHER'S MAIDEN NAME			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		
16. SOCIAL SECURITY NO. <u>219-05-6754</u>			17. INFORMANT <u>MR. MAURICE MILLER, 5821 GIST AVENUE #21215</u>		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <u>4/12/72</u> <u>Cardio-Respiratory Failure</u> (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Chronic Heart Failure</u> <u>Chronic Obstructive Pulmonary Disease (COPD)</u> <u>Gen. Arteriosclerosis</u>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Pacemaker Permanent</u>		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>August 1967</u> to <u>April 13, 1972</u> , that (I) (we) last saw the deceased alive on <u>April 13, 1972</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did not) view the body after death.					
23A. SIGNATURE <u>William D Applefeld</u>				23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) <u>William D Applefeld</u>				23D. ADDRESS <u>6615 Rustenstrom Rd</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>April 14/72</u>		24C. NAME OF CEMETERY or CREMATORY <u>Har Zion - Tifereth</u>	
24D. LOCATION (City, town, or county) (State) <u>Resdale, Maryland</u>		25A. DATE REC'D BY HEALTH DEPT. <u>APR 17 1972</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor, MD</u>	
25C. FUNERAL DIRECTOR <u>Salvatore J. Burs</u>		25D. ADDRESS <u>6010 Rustenstrom</u>		25E. SIGNATURE <u>Salvatore J. Burs</u>	

SECRET

SECRET

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>72 03633</u>
BIRTH NO. <u>13-242</u>		CERTIFICATE OF DEATH		72 03633
1. NAME OF DECEASED (Type or Print) <u>Bezelik, Mary</u>		2. DATE AND HOUR OF DEATH <u>4-13-72 10 PM</u>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>md</u> B. COUNTY <u>2505</u>		
FULL NAME OF HOSPITAL OR INSTITUTION <u>Harbor View</u>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>1213 Light St Balto - md.</u>		C. CITY OR TOWN <u>Baltimore</u>
5. SEX <u>F</u>		6. RACE <u>W</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>5/15/85</u>		9. AGE (In years last birthday) <u>86</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>chse lady</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Europe (Austria)</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Unknown</u>		
14. MOTHER'S MAIDEN NAME <u>Unknown</u>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		
16. SOCIAL SECURITY NO. <u>217-14-1308</u>		17. INFORMANT <u>Mrs Anna Bezelik Daughter in law.</u>		
18. CAUSE OF DEATH <u>436.91</u>		ADDRESS <u>4418 Prudence Balto 26 - Md.</u>		
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE <u>Pneumonia</u> DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 Week</u>
(B) <u>Cerebrovascular Accident</u> DUE TO, OR AS A CONSEQUENCE OF:		(C)		<u>7 Weeks</u>
II				
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				
19A. DATE OF OPERATION <u>13 April</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (if) (this hospital) attended the deceased from <u>12 March</u> 19 <u>72</u> to <u>13 April</u> 19 <u>72</u> that (I) (we) last saw the deceased alive on <u>13 April</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <u>Peter H Rheinstein, MD</u>		23B. DATE SIGNED <u>14 April 1972</u>		23C. PHYSICIAN'S NAME (Type) <u>PETER H RHEINSTEIN, MD</u>
23D. ADDRESS <u>HARBOR VIEW NURSING CENTER</u>		24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		
24B. DATE <u>4-17-72</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Holy Cross</u>		24D. LOCATION (City, town, or county) (State) <u>Ritchie Hwy Balto. MD.</u>
25A. DATE REC'D BY HEALTH DEPT. <u>APR 17 1972</u>		25B. NAME OF REGISTRAR <u>Paul E. Taylor, MD</u>		25C. FUNERAL DIRECTOR <u>Earl C. Lysen Jr</u>
25D. ADDRESS <u>4200 Pennington</u>		VS 150 REV. 1/1/68		

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. <u>72 03634</u>
BIRTH NO. <u>M-226</u>		72 03634		
1. NAME OF DECEASED (Type or Print) <u>MARY McCusker</u>		2. DATE AND HOUR OF DEATH <u>April 12 1972 - 7 P.M.</u>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <u>South Baltimore General Hosp.</u>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MD</u> B. COUNTY <u>2303</u>		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>South Baltimore General Hosp.</u>		C. CITY OR TOWN <u>BALTIMORE</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
E. STREET AND NUMBER <u>1701 Patapsco St.</u>				
5. SEX <u>Female</u>	6. RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb 3, 63</u>	9. AGE (In years last birthday) <u>9 yrs</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>NONE</u>		11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>				
13. FATHER'S NAME <u>Thomas McCusker</u>		14. MOTHER'S MAIDEN NAME <u>Mildred Buley</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u> </u>		17. INFORMANT <u>Chart</u>
18. <u>591X I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Chronic renal failure</u> <u>Recurrent Urinary tract infection & hydronephrosis</u>		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) <u> </u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>9 yrs</u> <u>9 yrs</u>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				
19A. DATE OF OPERATION <u> </u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u> </u>		20A. AUTOPSY? (Yes or No) <u> </u>
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u> </u>				
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u> </u>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <u> </u>
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) <u> </u>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <u> </u>
22. I certify that (I) (this hospital) attended the deceased from <u>April 3 1972</u> to <u>April 12 1972</u> that (I) (we) last saw the deceased alive on <u>April 12 1972</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <u>Sang Y. Rhim M.D.</u>		23B. DATE SIGNED <u>4/12/72</u>		
23C. PHYSICIAN'S NAME (Type) <u>SANG Y. RHIM M.D.</u>		23D. ADDRESS <u>South Baltimore General Hospital</u>		
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>4-15-72</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Glen Haven Memorial Park</u>
24D. LOCATION (City, town, or county) (State) <u>Glen Burnie, Maryland</u>				
25A. DATE REC'D BY HEALTH DEPT. <u>APR 17 1972</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor M.D.</u>		25C. FUNERAL DIRECTOR <u>McGully Funeral Home Balto., Md. 21230</u>



S-236

BALTIMORE CITY HEALTH DEPARTMENT
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

72 03635

BIRTH NO.

1. NAME OF DECEASED (Type or Print) LILLIAN SCHUSTER		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> April 13, 1972 M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 00 3618 Elmley Avenue		3. DATE PRONOUNCED DEAD Month Day Year April 13, 1972 7:55 A. M.	
5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY 2643			
6. SEX Female	7. RACE White	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	C. CITY OR TOWN Baltimore
9. DATE OF BIRTH 10 AUG 1900		10. AGE (In years last birthday) 71	D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	E. STREET AND NUMBER 3618 Elmley Avenue
13. FATHER'S NAME HENRY DEBELIUS		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE	
15. MOTHER'S MAIDEN NAME ELIZABETH E. FREEMAN		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) NO	
17. SOCIAL SECURITY NO. 214-20-4P16		18. INFORMANT LETUE H. DEBELIUS, 3416 CHESTERFIELD AVE	
19. 4-12-41 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 0		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) No			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?			
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Charles S. Springate M.D. EXAMINER'S NAME (Type) Charles S. Springate, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED April 13, 1972			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 17 APR. 72	
24C. NAME OF CEMETERY or CREMATORY OAK LAWN CEMETERY		24D. LOCATION (City, town, or county) (State) BALTO. CO., MD.	
25A. DATE REC'D BY HEALTH DEPT. APR 17 1972		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.	
25C. FUNERAL DIRECTOR ULRICH FUNERAL HOME, BALTO, MD. 21206		ADDRESS	

2000 57

STANDARD INTERNATIONAL A 115

20

STANDARD INTERNATIONAL A 115

20

STANDARD INTERNATIONAL A 115

20

STANDARD INTERNATIONAL A 115

20

STANDARD INTERNATIONAL A 115

20

STANDARD INTERNATIONAL A 115

20

STANDARD INTERNATIONAL A 115

20

STANDARD INTERNATIONAL A 115

20

STANDARD INTERNATIONAL A 115

20

STANDARD INTERNATIONAL A 115

20

STANDARD INTERNATIONAL A 115

20

STANDARD INTERNATIONAL A 115

20

STANDARD INTERNATIONAL A 115

20

STANDARD INTERNATIONAL A 115

20

STANDARD INTERNATIONAL A 115

20

STANDARD INTERNATIONAL A 115

20

STANDARD INTERNATIONAL A 115

20

STANDARD INTERNATIONAL A 115

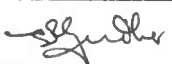
20

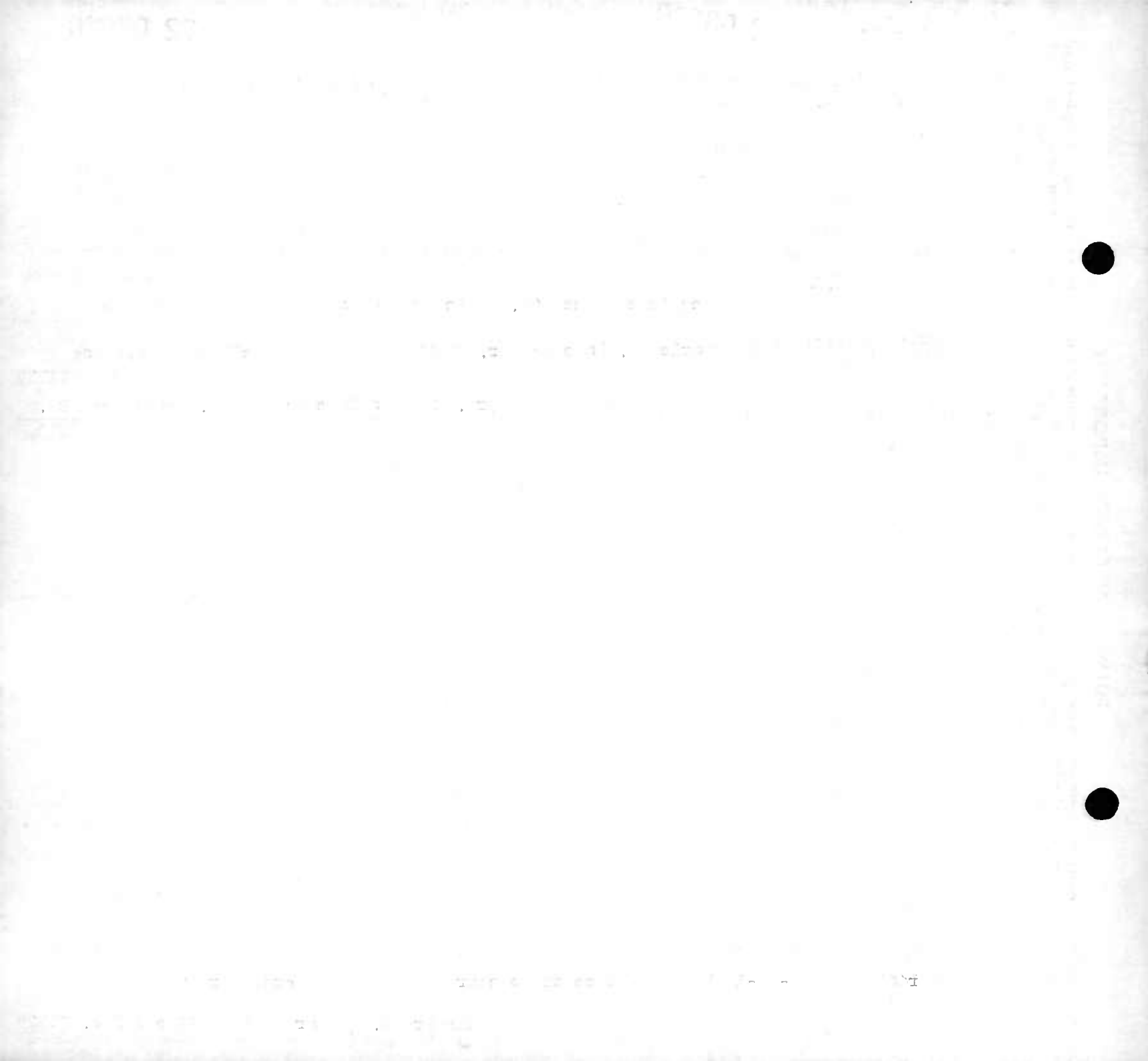
STANDARD INTERNATIONAL A 115

20

FUNERAL DIRECTOR: IMPORTANT

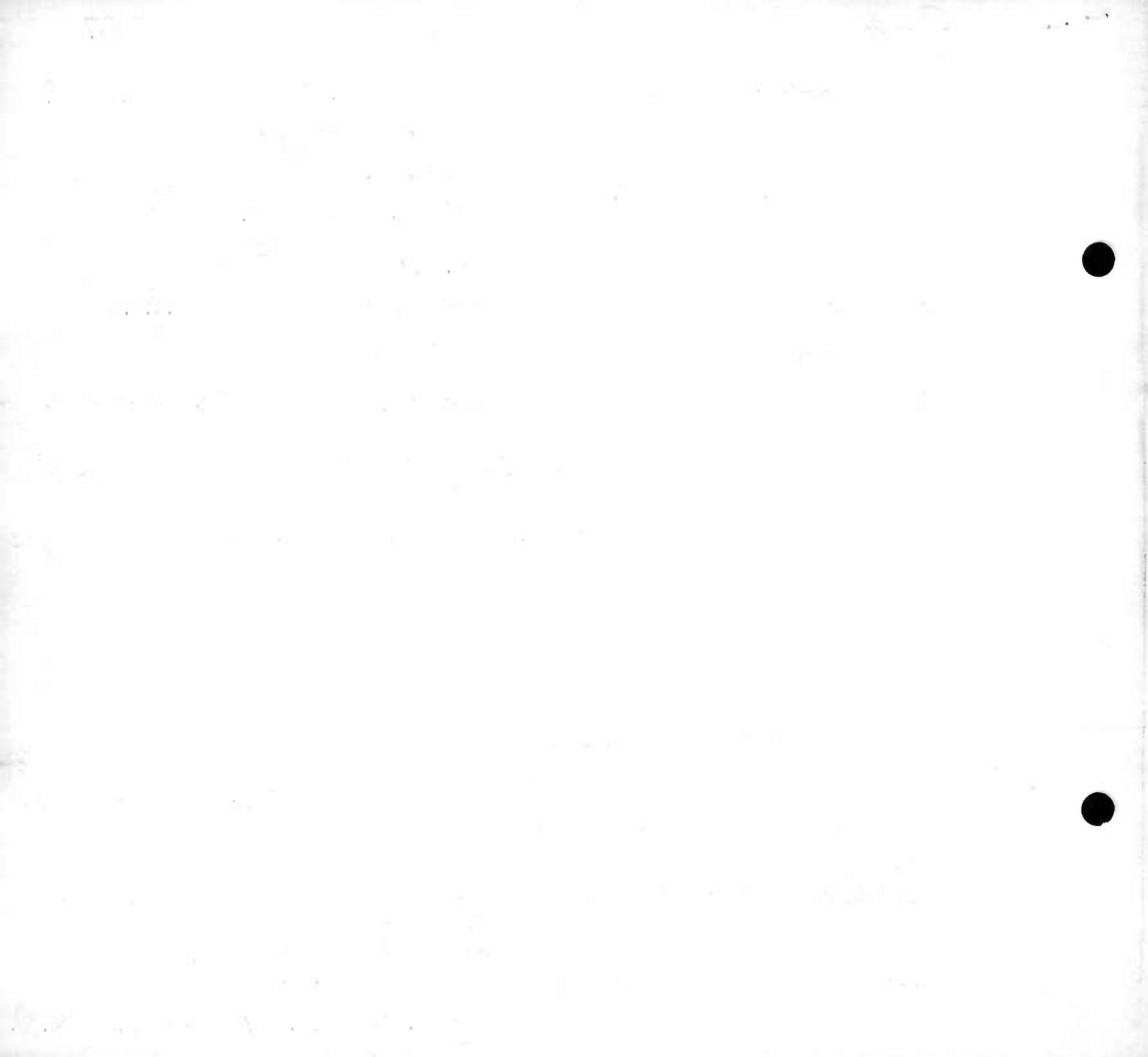
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>72 03636</u>	
<div style="display: flex; justify-content: space-between;"> R-152 72 03636 CERTIFICATE OF DEATH </div>					
BIRTH NO. _____					
1. NAME OF DECEASED (Type or Print) RAVENIS, CHARLES J.			2. DATE AND HOUR OF DEATH 4/13/72 at 11:35 P.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION 35 CHURCH HOME + HOSPITAL 100 N. BROADWAY, BALTIMORE 21231			A. STATE MD. B. COUNTY _____		
C. CITY OR TOWN BALTIMORE			D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
E. STREET AND NUMBER 759 S. WOODINGTON RD.					
5. SEX M	6. RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11/1/10	9. AGE (in years last birthday) 61	If Under 1 Yr. Months: _____ Days: _____ If Under 24 Hrs. Hours: _____ Min: _____
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10B. KIND OF BUSINESS OR INDUSTRY Bethlehem Steel Co.		11. BIRTHPLACE (State or foreign country) Pennsylvania	
12. CITIZEN OF WHAT COUNTRY? America					
13. FATHER'S NAME XXXXXXXXXXXX Charles J. Ravenis, Sr.			14. MOTHER'S MAIDEN NAME XXXXXXXXXXXX Nellie Mazaikas		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) unknown		16. SOCIAL SECURITY NO. 205-07-7488		17. INFORMANT Mrs. Eldonna Ravenis, 759 S. Woodington Rd.	
18. I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH Ca - (R) upper lobe of lung (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Ca - (R) upper lobe of lung		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF:			
(C) _____					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 3/24/72		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Ca - lung		20A. AUTOPSY? (Yes or No) _____	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) _____	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) _____		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? _____	
22. I certify that (I) (this hospital) attended the deceased from 3/17/1972 to 4/13/1972 that (I) (we) last saw the deceased alive on 4/13/1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE 			23B. DATE SIGNED 4/13/72		
23C. PHYSICIAN'S NAME (Type) S. P. GIRDHAR M.D.			23D. ADDRESS Church Home + Hospital 100 N. Broadway		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4-17-1972		24C. NAME of CEMETERY or CREMATORY Holy Redeemer Cemetery	
24D. LOCATION Baltimore, Maryland					
25A. DATE REC'D BY HEALTH DEPT. APR 17 1972		25B. NAME OF REGISTRAR Robert E. Fisher M.D.		25C. FUNERAL DIRECTOR Howard H. Hubbard, 4107 Wilkens Ave. 21229	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

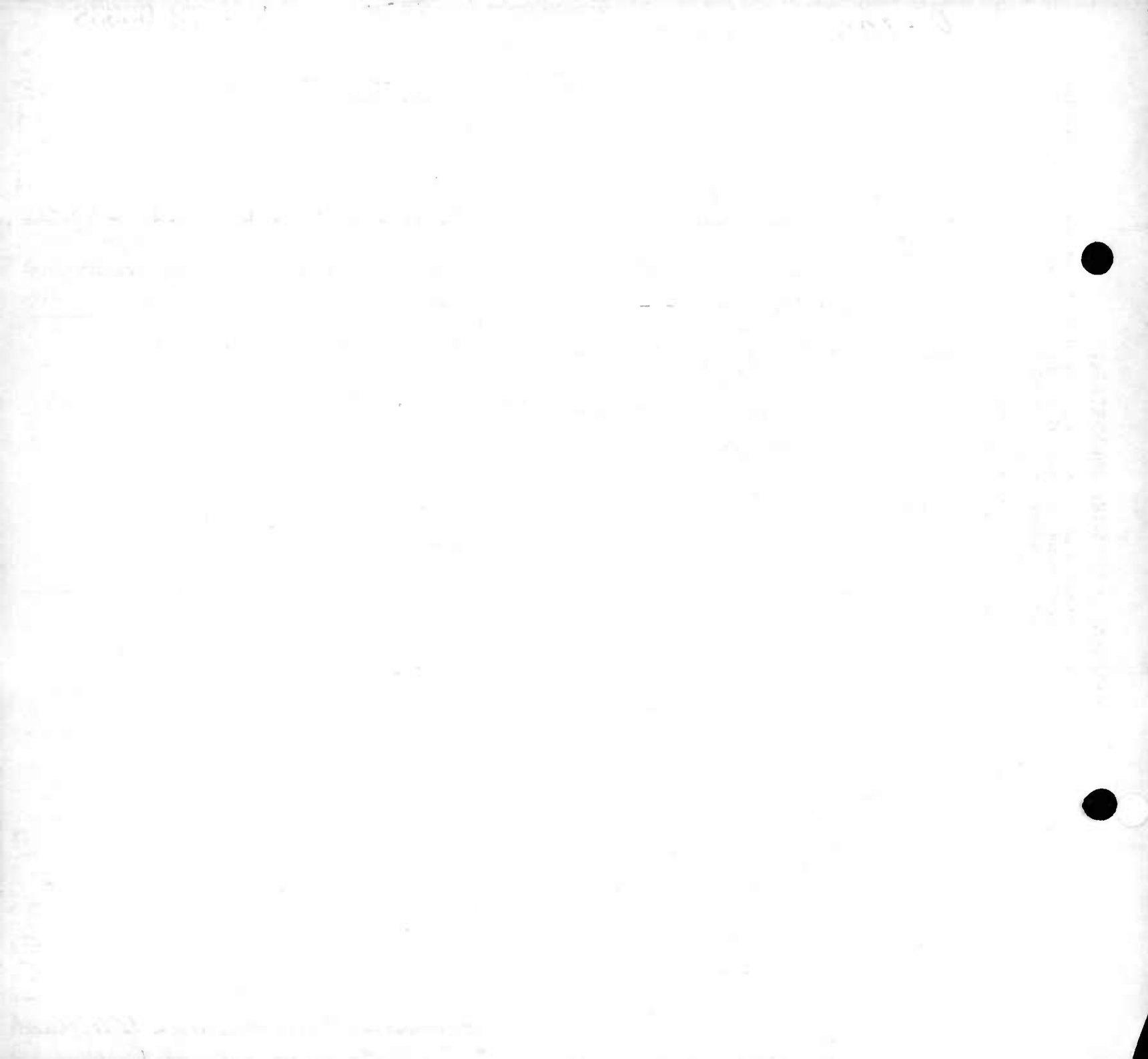
<p>BALTIMORE CITY HEALTH DEPARTMENT</p> <p>CERTIFICATE OF DEATH</p>		<p>REG. NO. <u>72 03637</u></p>	
<p>BIRTH NO. <u>R-436</u> <u>72 03637</u></p>		<p>2. DATE AND HOUR OF DEATH <u>4/13/72</u> <u>7:30</u> <u>P.</u> <u>M.</u></p>	
<p>1. NAME OF DECEASED (Type or Print) <u>William M. Rohleder</u></p>		<p>4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE <u>MD.</u> B. COUNTY <u>BALTO.</u></p>	
<p>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</p>		<p>5. SEX <u>F</u> 6. RACE <u>W</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/></p>	
<p>FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>00 2406 E. Jefferson St.</u></p>		<p>C. CITY OR TOWN <u>Balto. Md.</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></p>	
<p>10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Home maker</u></p>		<p>8. DATE OF BIRTH <u>Jan. 30, 1887</u> 9. AGE (In years last birthday) <u>85</u></p>	
<p>10B. KIND OF BUSINESS OR INDUSTRY</p>		<p>11. BIRTHPLACE (State or foreign country) <u>Baltimore City</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u></p>	
<p>13. FATHER'S NAME <u>Unknown</u></p>		<p>14. MOTHER'S MAIDEN NAME <u>Carrie Buck</u></p>	
<p>15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u></p>		<p>16. SOCIAL SECURITY NO. <u>-</u> 17. INFORMANT <u>Herbert H. Rohleder</u> ADDRESS <u>2406 E. Jefferson St.</u></p>	
<p>18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p>		<p>CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Coronary Occlusion</u> (B) DUE TO, OR AS A CONSEQUENCE OF: <u>Atherosclerotic Cardiovascular D 10 yrs</u> (C) _____</p>	
<p>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u></p>		<p>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).</p>	
<p>19A. DATE OF OPERATION <u>0</u> 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</p>		<p>20A. AUTOPSY? (Yes or No) <u>No</u> 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</p>	
<p>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/></p>		<p>21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)</p>	
<p>21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)</p>		<p>21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)</p>	
<p>21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/></p>		<p>21F. HOW DID INJURY OCCUR?</p>	
<p>22. I certify that (I) (this hospital) attended the deceased from <u>Jan 1</u> <u>1972</u> to <u>April 13</u> <u>1972</u> that (I) (we) last saw the deceased alive on <u>April 12</u> <u>1972</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</p>			
<p>23A. SIGNATURE <u>[Signature]</u> DEGREE</p>		<p>23B. DATE SIGNED <u>4/14/72</u></p>	
<p>23C. PHYSICIAN'S NAME (Type) <u>[Signature]</u></p>		<p>23D. ADDRESS <u>Balto 21237</u></p>	
<p>24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u></p>		<p>24B. DATE <u>4/17/72</u></p>	
<p>24C. NAME OF CEMETERY OR CREMATORY <u>Holy Redeemer</u></p>		<p>24D. LOCATION (City, town, or county) (State) <u>Balto. Md.</u></p>	
<p>25A. DATE REC'D BY HEALTH DEPT. <u>APR 17 1972</u></p>		<p>25B. NAME OF REGISTRAR <u>Robert E. Fisher, M.D.</u></p>	
<p>25C. FUNERAL DIRECTOR <u>John J. Miller, Inc.</u> ADDRESS <u>6415 Belair Rd. Balto. Md.</u></p>		<p>VS 150-REV. 1/1/68</p>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				CERTIFICATE OF DEATH		REG. NO. <u>72 03638</u>	
U-320		72 03638					
BIRTH NO.				1. NAME OF DECEASED (Type or Print) <u>FLOSSIE WATTS</u>		2. DATE AND HOUR OF DEATH <u>4-14-72</u> <u>1945</u> A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MD.</u> B. COUNTY <u>1307</u>			
FULL NAME OF HOSPITAL OR INSTITUTION <u>UNION Memorial Hospital</u>				C. CITY OR TOWN <u>BALTIMORE</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				E. STREET AND NUMBER <u>3916 ELM AVENUE 21211</u>			
5. SEX <u>F</u>	6. RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-6-93</u>	9. AGE (In years last birthday) <u>78</u>	10. Under 1 Yr. Months: <u>7</u> Days: <u>7</u>	11. Under 24 Hrs. Hours: <u>7</u> Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>- -</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>WILLIAM J. FOSTER</u>				14. MOTHER'S MAIDEN NAME <u>IDA M. LINNAGEN</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>214-22-1039</u>		17. INFORMANT <u>Elmer H. Watt 3916 Elm Avenue 21211</u>			
18. <u>590.01</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>Chronic Renal Failure.</u>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Chronic Pyelonephritis</u>				(B) DUE TO, OR AS A CONSEQUENCE OF:			
				(C) DUE TO, OR AS A CONSEQUENCE OF:			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <u>ASCUD - C. H. FAILURE.</u>							
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>YES</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH? (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) Month (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR			
22. I certify that (I) (this hospital) attended the deceased from <u>4-10</u> <u>1972</u> to <u>4-14</u> <u>1972</u> that (I) (we) last saw the deceased alive on <u>4-14-</u> <u>1972</u> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>Carlos A. Batillana</u>				23B. DATE SIGNED <u>4-14-72</u>		23C. PHYSICIAN'S NAME (Type) <u>CARLOS A. BATILLANA</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>4/17/72</u>		24C. NAME of CEMETERY or CREMATORY <u>Loudon Park Cemetery</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>APR 17 1972</u>		25B. NAME OF REGISTRAR <u>John E. Kelly, M.D.</u>		25C. FUNERAL DIRECTOR <u>Funeral Home 3588 Roland</u>		ADDRESS <u>1111 Ave</u>	



FUNERAL DIRECTOR IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>72 03639</u>	
E-524		72 03639		CERTIFICATE OF DEATH	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		Katie Engelhardt		4-13-72 10 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institutions residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			A. STATE B. COUNTY		
Union Memorial Hospital 44			MD 2735		
C. CITY OR TOWN			D. INSIDE CITY LIMITS?		
Baltimore			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
E. STREET AND NUMBER					
7617 Mars Avenue					
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
F	W	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	10-07-87	87	Housewife
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10B. KIND OF BUSINESS OR INDUSTRY		
Homemaker			Homemaker		
11. BIRTHPLACE (State or foreign country)			12. CITIZEN OF WHAT COUNTRY?		
Baltimore - U.S.A.			USA		
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
John Clusman			Mary Roate		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		
No			219-58-5200		
17. INFORMANT			ADDRESS		
Mrs. Katie D. Rugemer			21224		
3405 Elliott St. Balto.					
18. CAUSE OF DEATH			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH					
(This does not mean the mode of dying, e.g., suffocation, drowning, etc., but the disease or condition which caused death.)					
ANTECEDENT CAUSES					
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		
4-1-72			Fracture hip		
20A. AUTOPSY? (Yes or No)			20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
No					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		
			home		
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
7617 Mars Avenue					
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)			21E. INJURY OCCURRED		
3-31-72 1 PM			While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		
21F. HOW DID INJURY OCCUR?					
Falling					
22. I certify that (I) (this hospital) attended the deceased from 8-31-1922 to 4-13-1972 that (I) (we) last saw the deceased alive on 4-13-1972 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE			23B. DATE SIGNED		
Chasman Khany			4-13-72		
23C. PHYSICIAN'S NAME (Type)			23D. ADDRESS		
E. J. McDonnell			4-E. Madison St		
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		4/17/72		Parkwood Cemetery	
24D. LOCATION (City, town, or county) (State)		24E. NAME OF REGISTRAR		24F. FUNERAL DIRECTOR	
Parkville Balto. Md.				Tassahn Funeral Home 7401 Belair Rd. Balto.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
APR 17 1972				Tassahn Funeral Home 7401 Belair Rd. Balto.	

2

Baltimore

to

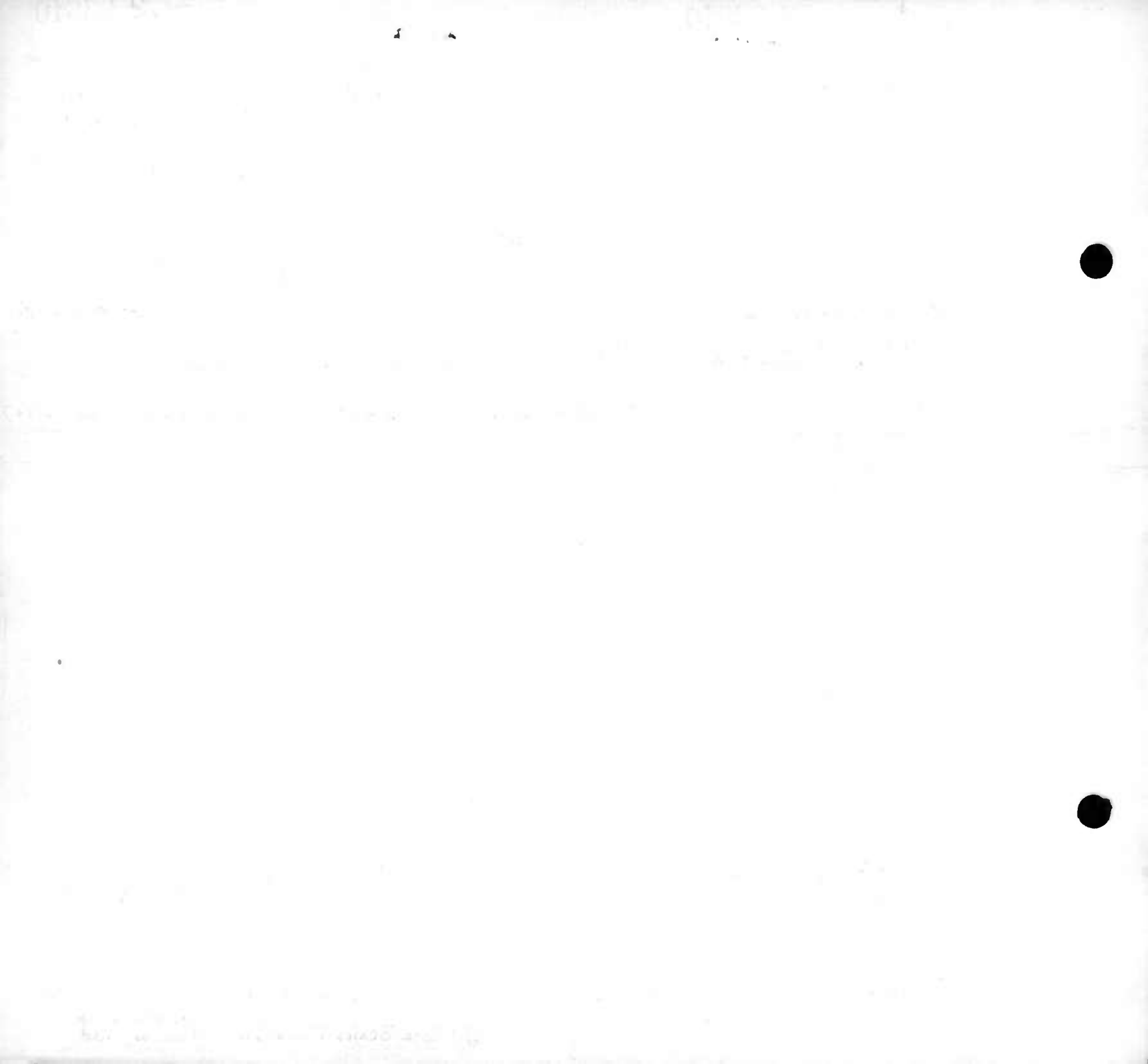
and the other of the same name

of the same name

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 72 03640			
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
Miller, Irene		4/12/72 2:30 PM	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			
FULL NAME OF HOSPITAL OR INSTITUTION Md General Hospital 48		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE Md 21201 B. COUNTY 1102	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER 900 Cathedral St			
5. SEX F	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5/25/96 9. AGE (in years lost birthday) 75
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) REGISTERED NURSE		10B. KIND OF BUSINESS OR INDUSTRY Hospital	
11. BIRTHPLACE (State or foreign country) Md		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME HENRY CURTIS MILLER		14. MOTHER'S MAIDEN NAME HENRIETTA TALBOT	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 214-30-7120	
17. INFORMANT Amos W. Basler		ADDRESS 3003 Ferndale Ave. 21207	
18. CAUSE OF DEATH			
DISEASE OR CONDITION DIRECTLY NOT A MELEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Cardiorespiratory Dist	
ANTECEDENT CAUSES M.D. CHIEF OR ASST. MEDICAL EXAMINER DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) Hyperkalemia (C) Dehydration	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (H) (this hospital) attended the deceased from 10 Apr 1972 to 12 Apr 1972 that (H) (we) last saw the deceased alive on 12 Apr 72 and that (H) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (H) (We) (did) (did not) view the body after death.			
23A. SIGNATURE [Signature]		23B. DATE SIGNED 4-12-72	
23C. PHYSICIAN'S NAME (Type) [Signature]		23D. ADDRESS	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 4-15-72	
24C. NAME OF CEMETERY OR CREMATORY Poplar Grove Cemetery		24D. LOCATION (City, town, or county) Cockeysville Md.	
25A. DATE REC'D BY HEALTH DEPT. APR 17 1972		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.	
25C. FUNERAL DIRECTOR Wm. Cook Brooks		ADDRESS 1050 York Rd Towson, Md.	



1

72 03641 BALTIMORE CITY HEALTH DEPARTMENT
MEDICAL EXAMINER'S CERTIFICATE OF DEATH REG. NO. **72 03641**

BIRTH NO. **D-526**

1. NAME OF DECEASED (Type or Print) Helen C. Dimisqr		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> 4 11 72 12:01 A.M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 31 Baltimore City Hospitals		3. DATE PRONOUNCED DEAD Month Day Year Hour 4 11 72 12:01 A.M.	
5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY AA 5210		C. CITY OR TOWN Annapolis D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
6. SEX Female	7. RACE White	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	
9. DATE OF BIRTH MARCH 1, 1905		10. AGE (In years last birthday) 68 If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Govt.		14B. KIND OF BUSINESS OR INDUSTRY	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		17. SOCIAL SECURITY NO. 215-16-026	
18. INFORMANT John E. Jones		ADDRESS 740 CAROLINA AVE. Ft. Lauderdale	
19. E 814.7		CAUSE OF DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE Multiple injuries DUE TO, OR AS A CONSEQUENCE OF:	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(B) DUE TO, OR AS A CONSEQUENCE OF:	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		(C) _____	
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Street	
22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.) 4 10 72 7:10 P.m.		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? Eastern Blvd. 22' E. of Island Pt. Rd.		22F. HOW DID INJURY OCCUR? Pedestrian struck by auto	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE OF EXAMINER'S NAME (Type) Werner U. Spitz, M.D.		Deputy CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE April 15, 1972	
24C. NAME OF CEMETERY or CREMATORY Louisa Park Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore Md.	
25A. DATE REC'D BY HEALTH DEPT. APR 17 1972		25B. NAME OF REGISTRAR Robert E. Jones, M.D.	
25C. FUNERAL DIRECTOR Amrose Inc. 1378		ADDRESS Lebanon Spring Rd.	

VS 151-REV. 1/1/68

1430 ST

1430 ST

1430 ST

VALLEY FORD

VALLEY FORD

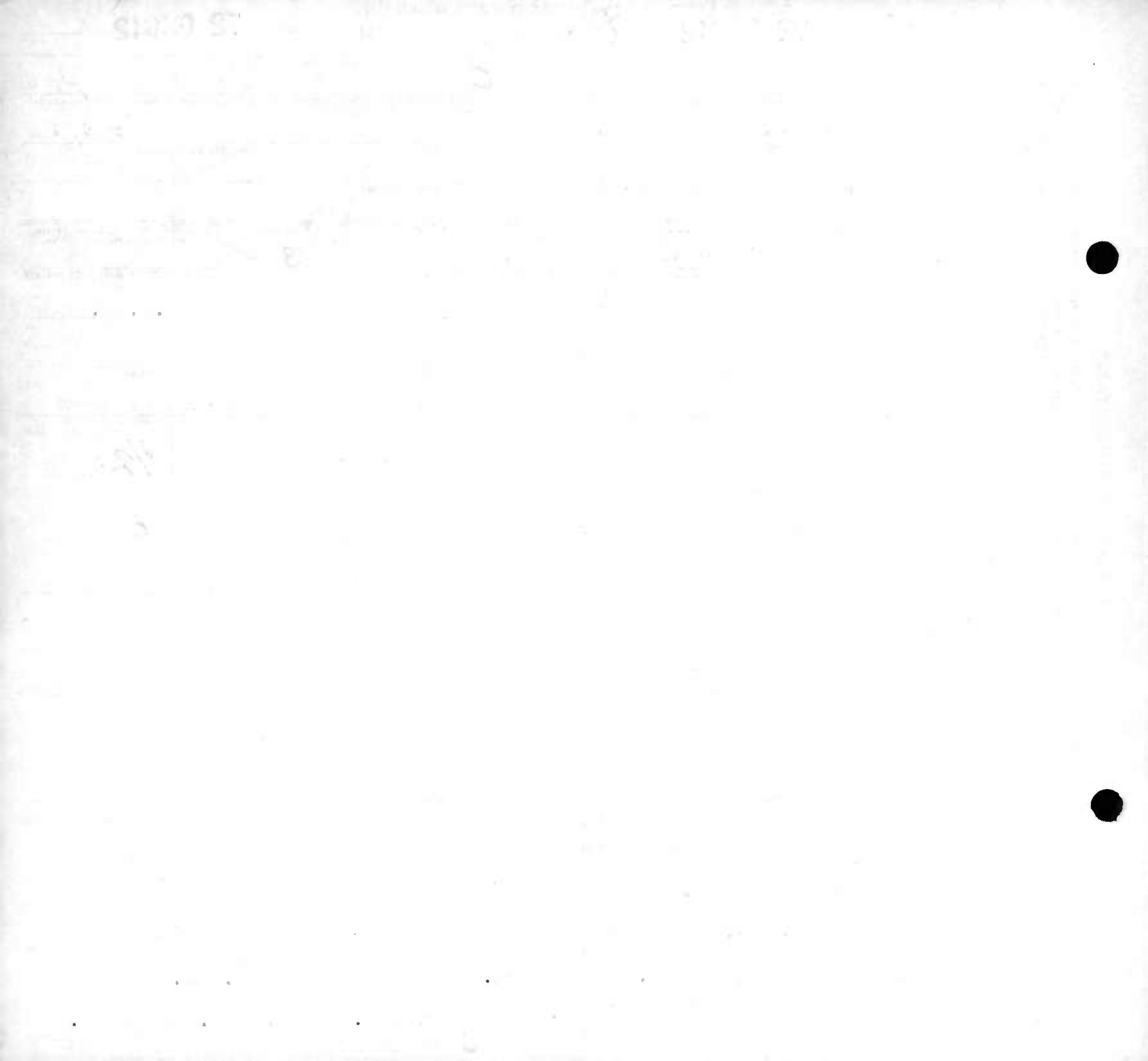
General - Antiques, Books, Maps, etc.

Phone 221-1111

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 03642	
<div style="display: flex; justify-content: space-between;"> W-362 72 03642 CERTIFICATE OF DEATH </div>					
<div style="display: flex; justify-content: space-between;"> <div> BIRTH NO. 1. NAME OF DECEASED <small>Type or Print</small> Witherspoon, Joseph H. O. </div> <div> 2. DATE AND HOUR OF DEATH 12:00 (4/14/72) </div> </div>					
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION The Johns Hopkins Hospital			4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE B. COUNTY MD. 501		
5. SEX MALE			6. RACE BLACK		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student			10B. KIND OF BUSINESS OR INDUSTRY School		8. DATE OF BIRTH 6-25-58
13. FATHER'S NAME Witherspoon, HARRY			14. MOTHER'S MAIDEN NAME Beane, Virginia		9. AGE (In years last birthday) 13
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <input type="checkbox"/>			16. SOCIAL SECURITY NO.		11. BIRTHPLACE (State or foreign country) Maryland
17. INFORMANT Virginia Witherspoon Same as Above			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
18. CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <small>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)</small> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 42 hrs 26 hrs.	
(A) IMMEDIATE CAUSE DE TO, OR AS A CONSEQUENCE OF: CR anast					
(B) MURINOCEREMIA DE TO, OR AS A CONSEQUENCE OF:					
(C)					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indify medical examined) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 4/12 1972 to 4/14 1972 that (I) (we) lost saw the deceased alive on 4/14 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Jerome E. Kurent				23B. DATE SIGNED 4/14/72	
23C. PHYSICIAN'S NAME (Type) Jerome E. Kurent, MD				23D. ADDRESS The Johns Hopkins Hospital	
24A. BURIAL CREMATION (Specify) Burial		24B. DATE 6/17/72		24C. NAME of CEMETERY or CREMATORY MT. Auburn Cemr	
24D. LOCATION (City, town, or county) (State) Baltimore, Md.					
25A. DATE RECD BY HEALTH DEPT APR 17 1972		25B. NAME OF REGISTRAR Charles F. Rice		25C. FUNERAL DIRECTOR (Address) Charles A. Rice 661 W. Barre ST.	



1. NAME OF DECEASED (Type or Print)		2. DATE OF DEATH		3. DATE PRONOUNCED DEAD		4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
Italo BRUNO SARACENI		Known <input checked="" type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> April 12, 1972 M.		Month Day Year Hour April 12, 1972 5:30 P. M.		University Hospital (DOA)		A. STATE Maryland B. COUNTY Prince Georges 6600	
6. SEX Male		7. RACE White		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Hillcrest Heights YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		D. INSIDE CITY LIMITS?	
9. DATE OF BIRTH Sept 2, 1929		10. AGE (In years lost birthday) 42		11. BIRTHPLACE (State or foreign country) Italy		12. CITIZEN OF WHAT COUNTRY? Italy		13. FATHER'S NAME Antonio Saraceni	
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Brick Layer		14B. KIND OF BUSINESS OR INDUSTRY		15. MOTHER'S MAIDEN NAME Serafina Unknown		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		17. SOCIAL SECURITY NO. 217 66 0172	
18. INFORMANT Alba Saraceni		ADDRESS 5955 23rd Parkway Hillcrest Hgt.		19. CAUSE OF DEATH Massive laceration of mesentery with hemorrhage into peritoneum and retroperitoneum		20. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) Yes		22. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) E. of Greenbelt on Route #495		22F. HOW DID INJURY OCCUR? (Prince Georges County) Driver in auto=tractor-trailer collision	
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Highway		22C. WHERE DID INJURY OCCUR? E. of Greenbelt on Route #495		22D. TIME OF INJURY (Month) (Day) (Year) (Hour) 4-12-72 4:45 P.m.		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>	
24. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4-15-72		24C. NAME of CEMETERY or CREMATORY Resurrection Cemetery		24D. LOCATION (City, town, or county) (State) Clinton Maryland		25A. DATE REC'D BY HEALTH DEPT. APR 17 1972	
25A. DATE REC'D BY HEALTH DEPT. APR 17 1972		25B. NAME OF REGISTRAR Robert E. ...		25C. FUNERAL DIRECTOR Wilhelm Funeral Home		25D. ADDRESS Suitland Maryland		25E. DATE SIGNED April 13, 1972	

10000000

10000000

10000000

10000000

10000000

10000000

10000000

10000000

10000000

10000000

10000000

10000000

10000000

10000000

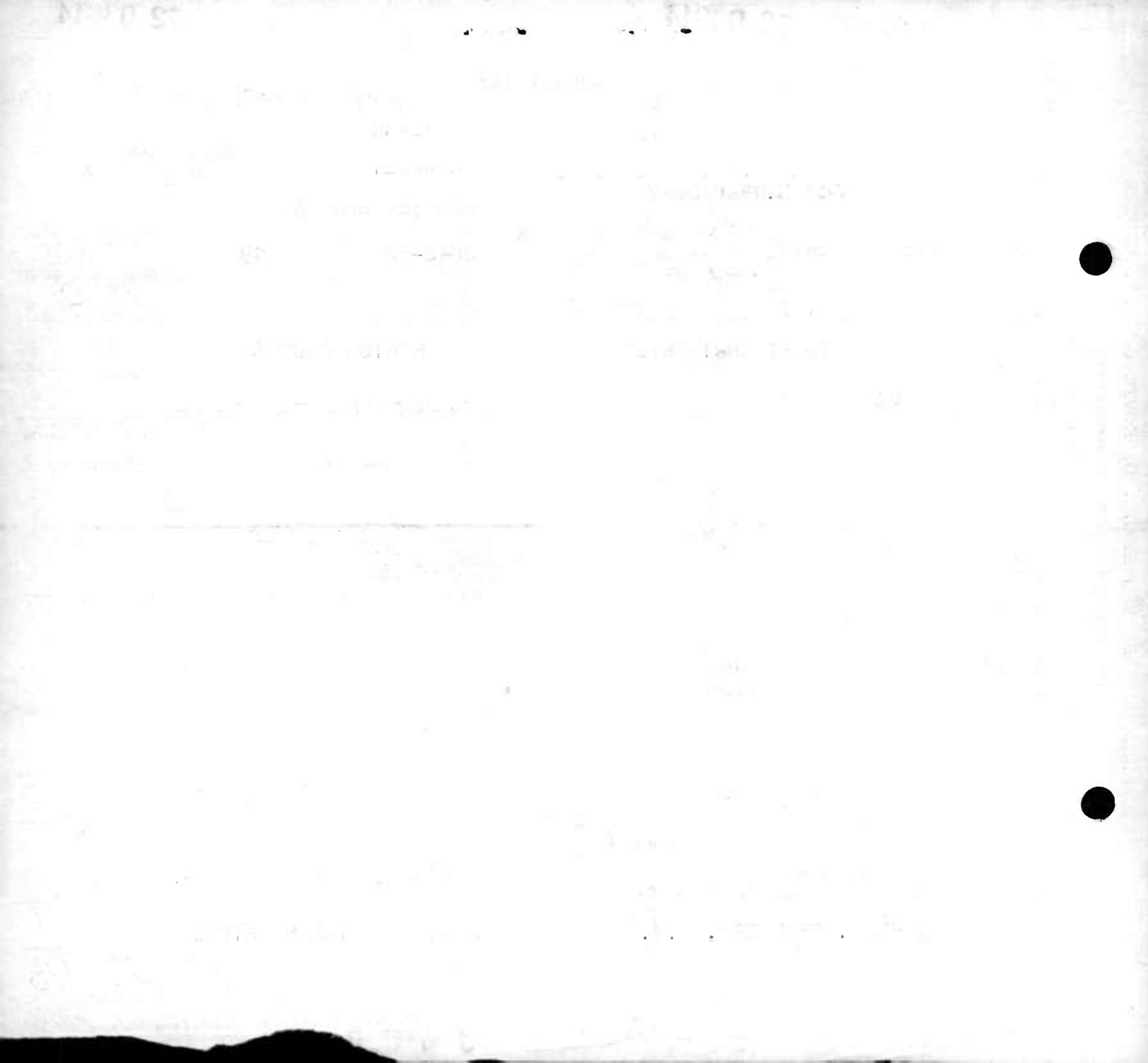
10000000

10000000

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

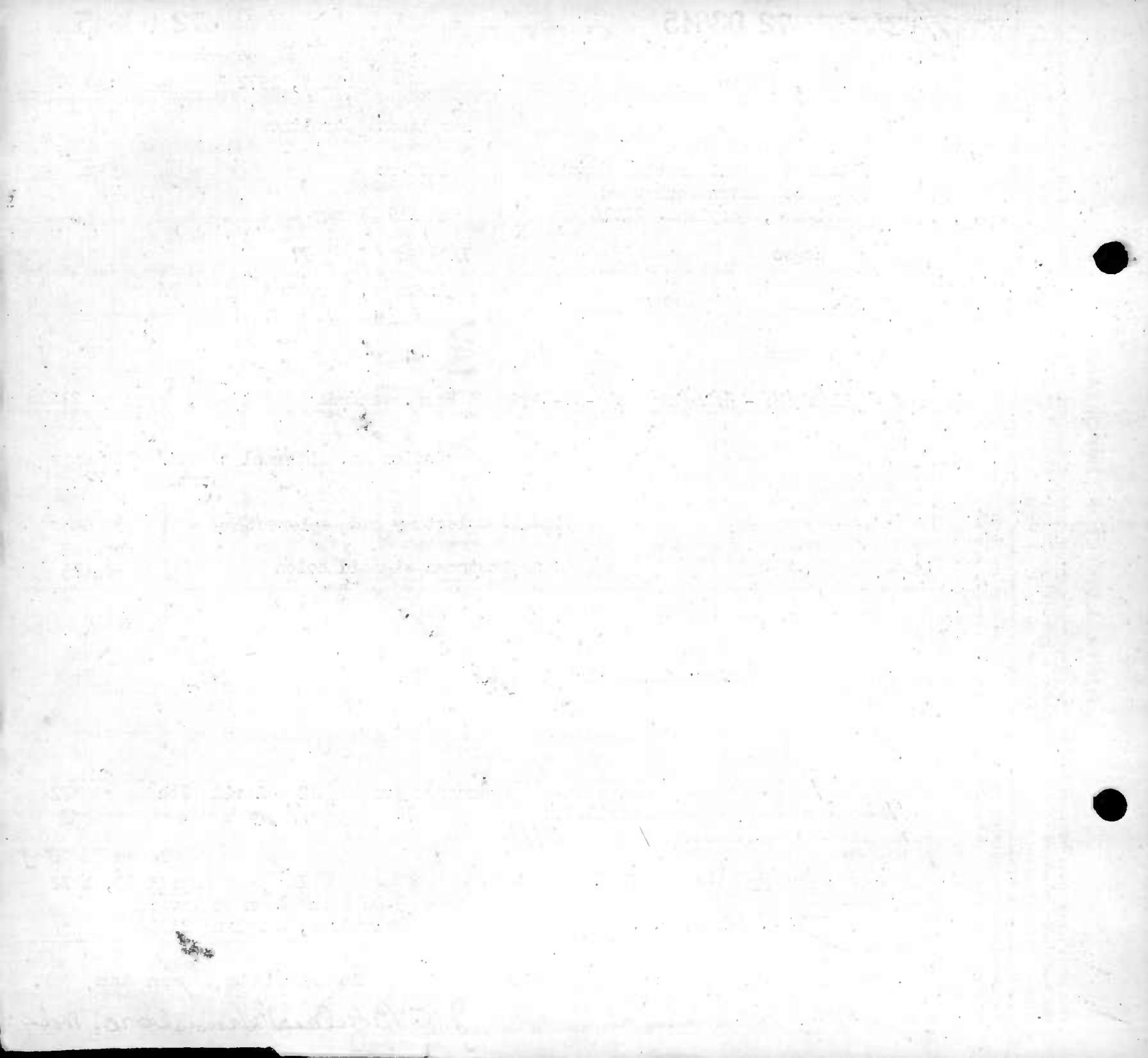
Baltimore City Health Department				72 03644	
C-623				72 03644	
BIRTH NO.				REG. NO.	
1. NAME OF DECEASED (Type or Print)			2. DATE AND HOUR OF DEATH		
GEOFFREY MORAN CHRISTHILF			4/11/72 9:00 P.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			A. STATE B. COUNTY		
33 JOHNS HOPKINS HOSPITAL 601 N. BROADWAY			MARYLAND AA 5200		
5. SEX			6. RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
MALE			WHITE		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH			9. AGE (in years last birthday)		10. UNDER 1 Yr. Months: Days: 11. UNDER 24 Hrs. Hours: Min.
0848-52			19		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)
STUDENT			SCHOOL		MD.
12. CITIZEN OF WHAT COUNTRY?			13. FATHER'S NAME		
U.S.A.			STUART CHRISTHILF		
14. MOTHER'S MAIDEN NAME			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		
MARION FROMEN			NO		
16. SOCIAL SECURITY NO.			17. INFORMANT		
			STUART M. CHRISTHILF		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH			CAUSE OF DEATH		
CRANIO CEREBRAL INJURIES			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			4/10/72		
(B) DUE TO, OR AS A CONSEQUENCE OF:			9/10/72		
(C) FELL 40 FT			9/10/72		
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
4/10/72		Head Trauma		Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
		Home		Home Annapolis 52-00	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
4/10/72		While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		Fell 40 ft from roof	
22. I certify that (I) (this hospital) attended the deceased from 4-10-72 to 4-11-72 that (I) (we) last saw the deceased alive on 4-11-72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
John W. Chambers M.D.				4/11/72	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
JOHN W. CHAMBERS, M.D.				JOHNS HOPKINS HOSPITAL	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY	
Burial		4-15-72		St. Marys	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
APR 17 1972		Robert E. ...		John M. ...	
25D. ADDRESS					
A.A. MD.					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

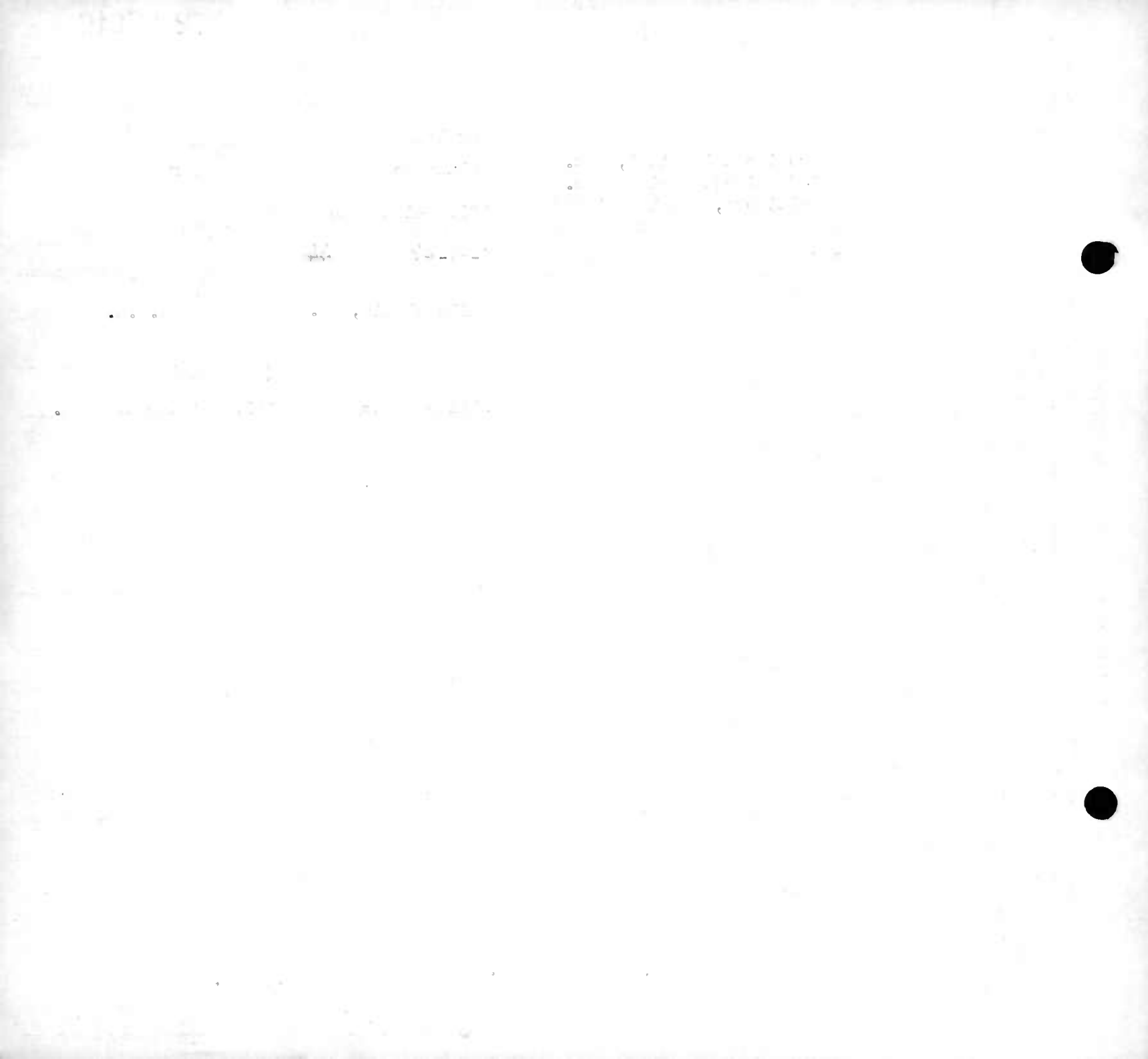
BALTIMORE CITY HEALTH DEPARTMENT				CERTIFICATE OF DEATH		REG. NO. <u>72 03645</u>	
BIRTH NO. <u>H-530 72 03645</u>							
1. NAME OF DECEASED (Type or Print) <u>HUNT, Walter</u>				2. DATE AND HOUR OF DEATH <u>April 7, 1972</u> <u>9:30 P</u> M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>23 Veterans Administration Hospital</u> <u>3900 Loch Raven Boulevard</u> <u>Baltimore, Maryland 21218</u>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>Caroline</u> C. CITY OR TOWN <u>Goldsboro</u> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER <u>Box 119 Cherry Lane</u>			
5. SEX <u>Male</u>	6. RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>7/25/94</u>	9. AGE (In years last birthday) <u>77</u>	10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farm Laborer</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>No Record</u>				14. MOTHER'S MAIDEN NAME <u>No Record</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>Yes</u> <u>11/10/14 - 5/16/19</u>		16. SOCIAL SECURITY NO. <u>217-54-8332</u>		17. INFORMANT ADDRESS <u>VA Hosp. Records Baltimore, Maryland 21218</u>			
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>II</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). 19A. DATE OF OPERATION <u>4/5/72</u> 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Adenocarcinoma sigmoid colon</u> 20A. AUTOPSY? (Yes or No) <u>YES</u> 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>YES</u> 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>Adenocarcinoma sigmoid colon</u> 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> 21F. HOW DID INJURY OCCUR? 22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>February 23rd</u> 19 <u>72</u> to <u>April 7th</u> 19 <u>72</u> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>April 7th</u> 19 <u>72</u> and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) (did) <input checked="" type="checkbox"/> (did not) view the body after death. 23A. SIGNATURE <u>John W. Baker MD</u> 23B. DATE SIGNED <u>April 10, 1972</u> 23C. PHYSICIAN'S NAME (Type) <u>JOHN W. BAKER, M.D.</u> 23D. ADDRESS <u>3900 Loch Raven Boulevard</u> <u>Baltimore, Maryland 21218</u> 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> 24B. DATE <u>4-13-72</u> 24C. NAME of CEMETERY or CREMATORY <u>Chesterfield</u> 24D. LOCATION (City, town, or county) (State) <u>Centerville, Queen Ann, Md.</u> 25A. DATE REC'D BY HEALTH DEPT. <u>APR 17 1972</u> 25B. NAME OF REGISTRAR <u>Robert E. Taylor, M.D.</u> 25C. FUNERAL DIRECTOR ADDRESS <u>J. E. Boulais Greensboro, Md.</u>							



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>72 03646</u>	
J-525 72 03646		CERTIFICATE OF DEATH			
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>Rosetta Johnson</u>		2. DATE AND HOUR OF DEATH <u>April 14, 1972</u> <u>5⁵⁵</u> <u>A.M.</u>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <u>39</u> Provident Hospital, Inc. 2600 Liberty Height Ave. Baltimore, Maryland 21215		A. STATE <u>Maryland</u>		B. COUNTY <u>1304</u>	
5. SEX <u>Female</u>		6. RACE <u>Negro</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <u>4-17-27</u>		9. AGE (In years last birthday) <u>44</u>		If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Philadelphia, Pa.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
15. Was Deceased Ever In U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>212226974</u>		17. INFORMANT (Daughter) ADDRESS <u>Elaine Banks 2237 Reisterstown Rd.</u>	
18. <u>250.9 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteonia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Hypoglycemia</u> (B) <u>Diabetes Mellitus</u> DUE TO, OR AS A CONSEQUENCE OF: (C) _____			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>April 13</u> 19 <u>72</u> to <u>April 14</u> 19 <u>72</u> that (I) (we) last saw the deceased alive on <u>April 14</u> , 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Lewis B. Boone</u> M.D. DEGREE		23B. DATE SIGNED <u>April 14, 1972</u>		23C. ADDRESS <u>Provident Hospital Baltimore Md.</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>4-18-72</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Mt. Auburn Cem.</u>	
24D. LOCATION <u>Balto., Md.</u>		25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR <u>Kelson J. H.</u>	
25C. FUNERAL DIRECTOR <u>V. Bailey</u>		25D. ADDRESS <u>1348 Calhoun Street</u>			



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 72 03647

BIRTH NO.

1. NAME OF DECEASED (Type or Print) LEON P. KNIGHT		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 00 2865 Edgecomb Circle North		3. DATE PRONOUNCED DEAD Month Day Year Hour April 13, 1972 12:45 A.M.	
6. SEX Male		7. RACE Negro	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore	
9. DATE OF BIRTH 3-3-05		10. AGE (In years last birthday) 67	
11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) janitorial		14B. KIND OF BUSINESS OR INDUSTRY	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO. 218100751A	
18. INFORMANT Julia Gale		ADDRESS 2407 Brookfield Ave.	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED. WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?		21. AUTOPSY? (Yes or No) Yes	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <i>Charles S. Springate</i> M.D. EXAMINER'S NAME (Type) Charles S. Springate, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED April 13, 1972			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4-17-72	
24C. NAME OF CEMETERY or CREMATORY Mt. Auburn Cem.		24D. LOCATION (City, town, or county) (State) Balto., Md.	
25A. DATE REC'D BY HEALTH DEPT. APR 17 1972		25B. NAME OF REGISTRAR Bailey	
25C. FUNERAL DIRECTOR Kelson F.H.		ADDRESS 1348 Calhoun Street	

1980 S.

1980 S.

1980 S.



7293 12-1
FUNERAL DIRECTOR: - IMPORTANT
DR. TUMANON

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

H-354		72 03648		BALTIMORE CITY HEALTH DEPARTMENT		72 03648	
BIRTH NO.		CERTIFICATE OF DEATH		REG. NO.			
1. NAME OF DECEASED (Type or Print) Hudnell Grace				2. DATE AND HOUR OF DEATH April 10 1972 11:05 A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 91 Montebello State Hospital				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY 1303 C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 2513 McCulloh St.			
5. SEX F		6. RACE B		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH 2-21-1909	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ELEVATOR OPERATOR		10B. KIND OF BUSINESS OR INDUSTRY —		9. AGE (In years last birthday) 63		11. BIRTHPLACE (State or foreign country) GA.	
13. FATHER'S NAME Levitticus Wynn				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
14. MOTHER'S MAIDEN NAME Wadie Youngblood				15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) UNKNOWN			
16. SOCIAL SECURITY NO.				17. INFORMANT PATIENT'S chart			
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshtenio, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). Pseudomucinous cystadenocarcinoma Left Ovary Since 1963				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH (A) IMMEDIATE CAUSE SHOCK DUE TO, OR AS A CONSEQUENCE OF: 3 HRS. (B) Intestinal obstruction DUE TO, OR AS A CONSEQUENCE OF: 2 days (C) Pseudomyxoma Peritonei chronic since 1963			
19A. DATE OF OPERATION June 1971 J.H.H.				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Colostomy Intestinal obstruction		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from December 7 1971 to April 10, 1972 that (I) (we) last saw the deceased alive on April 10, 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Rhodora C. Tumanon M.D.				23B. DATE SIGNED April 11, 1972		23C. PHYSICIAN'S NAME (Type) RHODORA C. TUMANON M.D.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial				24B. DATE 4-15-72		24C. NAME OF CEMETERY or CREMATORY Arbutus Mem Pk.	
25A. DATE REC'D BY HEALTH DEPT. APR 17 1972				25B. NAME OF REGISTRAR Robert E. Faber M.D.		25C. FUNERAL DIRECTOR V.R. Bailey	
26A. ADDRESS 2201 ARGONNE DRIVE Baltimore, Md.				26B. ADDRESS 1348 N. Calhoun St.			



BALTIMORE CITY HEALTH DEPARTMENT			
MEDICAL EXAMINER'S CERTIFICATE OF DEATH			
BIRTH NO.		REG. NO. 72 03649	
1. NAME OF DECEASED (Type or Print) CLIFTON HANNA		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 37 PROVIDENT HOSPITAL		3. DATE PRONOUNCED DEAD Month Day Year Hour April 15, 1972 4:55 A. M.	
6. SEX Male		7. RACE Negro	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore	
9. DATE OF BIRTH 5-8-49		10. AGE (In years lost birthday) 22	
11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		14B. KIND OF BUSINESS OR INDUSTRY Paper Co.	
15. MOTHER'S MAIDEN NAME Annie Clevon		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no	
17. SOCIAL SECURITY NO.		18. INFORMANT Alex Hanna	
19. E965X1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		CAUSE OF DEATH Gunshot wound of abdomen (back) (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:	
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) yes		22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	
22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Street		22C. WHERE DID IT INJURY OCCUR? (If in Baltimore City, give exact location) 1200 Block Calhoun Street	
22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.) 4-14-72 9:45 P. M.		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	
22F. HOW DID INJURY OCCUR? Shot while walking down street		23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>	
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Ronald N. Kornblum, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
DATE SIGNED 4/15/72		24A. BURIAL CREMATION, REMOVAL (Specify) Burial	
24B. DATE 4-19-72		24C. NAME OF CEMETERY or CREMATORY Mt. Auburn Cem.	
24D. LOCATION (City, town, or county) (State) Balto., Md.		25A. DATE REC'D BY HEALTH DEPT. APR 17 1972	
25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR V. Bailey	
ADDRESS Kelson F.H. 1348 Calhoun St.			

PAID ST.

PAID ST.

PAID ST.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

F-460		72 03650		BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		REG. NO. 72 03650	
1. NAME OF DECEASED (Type or Print) <u>Mammie Fuller</u>				2. DATE AND HOUR OF DEATH <u>4-15-72</u> <u>11⁰⁰</u> P.M.					
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MD</u> B. COUNTY <u>2003</u>					
FULL NAME OF HOSPITAL OR INSTITUTION <u>Bon Secours Hospital</u>				C. CITY OR TOWN <u>BALTIMORE</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				E. STREET AND NUMBER <u>3000 Ramsey Street</u>					
5. SEX <u>7</u>	6. RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>3-12-84</u>		9. AGE (In years last birthday) <u>88</u>		10. If Under 1 Yr. Months Days If Under 24 Hrs. Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>unknown</u>				14. MOTHER'S MAIDEN NAME <u>unknown</u>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or doles of service) <u>NO</u>				16. SOCIAL SECURITY NO. <u>81610-6444</u>		17. INFORMANT <u>Mr. William Miller - 2000 Ramsey St. Balto. Md.</u>			
18. <u>573.91</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Congestive heart failure</u>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>3 months</u>	
				(B) <u>Bronchopneumonia</u> DUE TO, OR AS A CONSEQUENCE OF: <u>??</u>					
				(C) <u>Liver disease</u> DUE TO, OR AS A CONSEQUENCE OF: <u>??</u>					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).									
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from <u>6/15/72</u> 19 to <u>4/15/72</u> 19 that (I) (we) last saw the deceased alive on <u>4/15/72</u> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <u>Yunyong Yunyongying M.D.</u>				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>4/15/72</u>			
23C. PHYSICIAN'S NAME (Type) <u>YUNYONG YUNYONGYING</u>				23D. ADDRESS <u>BON SECOURS HOSPITAL</u>					
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>4/18/72</u>		24C. NAME OF CEMETERY OR CREMATORY <u>London Park Cem.</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>			
25A. DATE REC'D BY HEALTH DEPT. <u>APR 17 1972</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor, M.D.</u>		25C. FUNERAL DIRECTOR <u>City of Baltimore, Inc.</u>		ADDRESS <u>201 Frederick Ave. Balto. Md. 21223</u>			

(15/10)

18. 10. 1914

18. 10. 1914

18. 10. 1914

18. 10. 1914

18. 10. 1914

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

S-520		72 03651		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. [REDACTED]	
1. NAME OF DECEASED (Type or Print) Lottie M. Sims				2. DATE AND HOUR OF DEATH 4-15-72 10:40 A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD 48 Maryland General Hospital.				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Ma. B. COUNTY 21213 841			
FULL NAME OF HOSPITAL OR INSTITUTION 48 Maryland General Hospital.				C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input checked="" type="checkbox"/>	
				E. STREET AND NUMBER 3156 Ravenwood Ave.			
5. SEX F	6. RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8-12-1917	9. AGE (In years last birthday) 54	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Va.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.				13. FATHER'S NAME Samuel B. Gunter			
14. MOTHER'S MAIDEN NAME Virgie Wright				15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			
16. SOCIAL SECURITY NO. 231 20 2548				17. INFORMANT Mr Robert M. Sims			
18. 4-12-4 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: CARDIAC & Respiratory arrest - AKA (B) Anteriosclerotic cardiovascular disease (C) Peripheral Vascular disease				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION 4/14/72		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Peripheral Vascular disease		20A. AUTOPSY? (Yes or No) yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from April 4 1972 to April 15 1972 and that (I) (we) last saw the deceased alive on April 15 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE [Signature]				23B. DATE SIGNED April 15, 1972		23C. PHYSICIAN'S NAME (Type) [Signature]	
23D. ADDRESS Baltimore Maryland 21213 Maryland General Hospital				24A. BURIAL CREMATION, REMOVAL (Specify) Burial			
24B. DATE 4/18/72				24C. NAME of CEMETERY or CREMATORY Maury			
24D. LOCATION Richmond Virginia				25A. DATE REC'D BY HEALTH DEPT. APR 17 1972			
25B. NAME OF REGISTRAR [Signature]				25C. FUNERAL DIRECTOR Henry Sander & Sons Inc.			

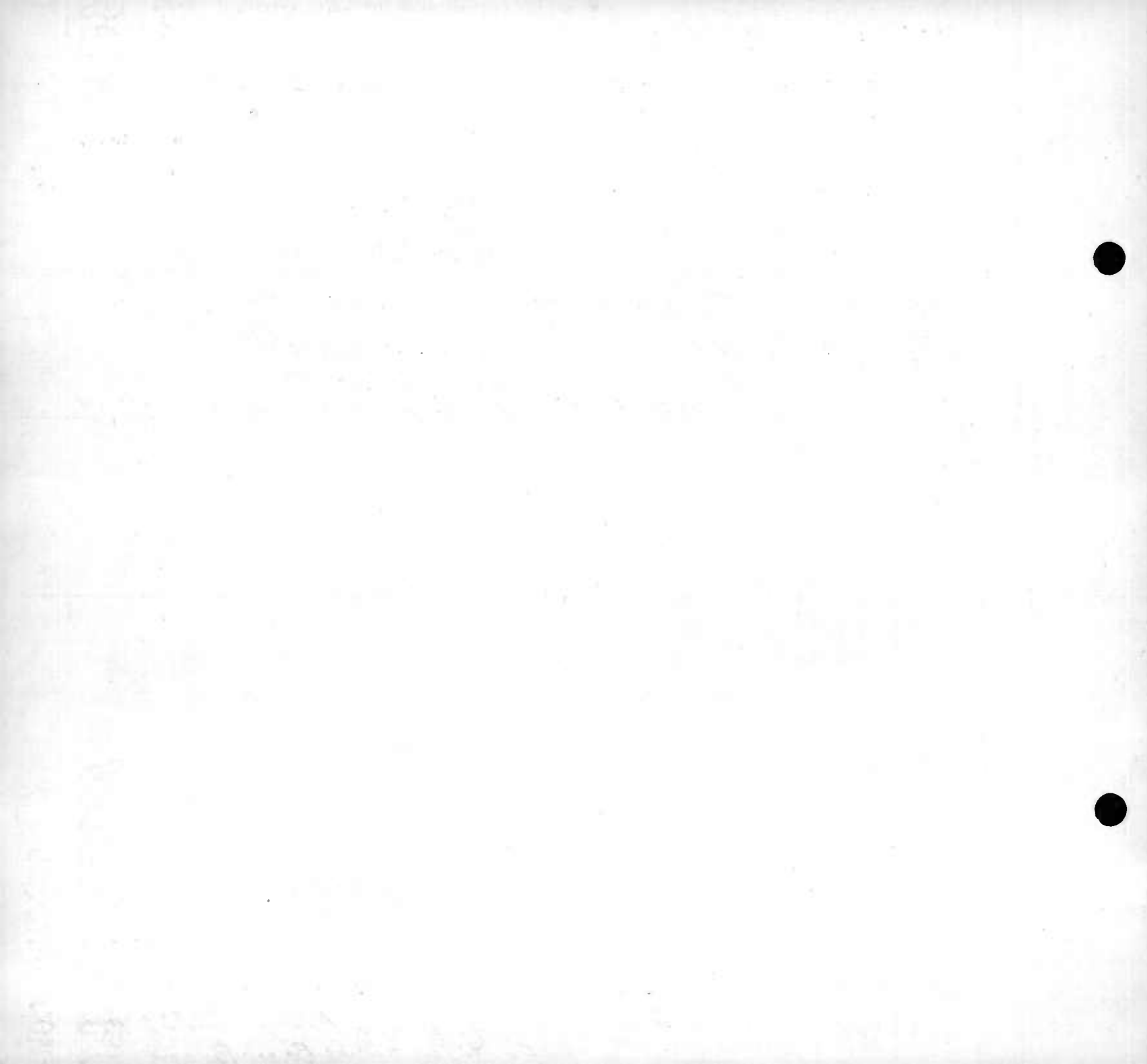


BIRTH NO.		REG. NO.	
1. NAME OF DECEASED (Type or Print) REGINALD LANE		2. DATE OF DEATH Known <input type="checkbox"/> Estimated <input type="checkbox"/> Month April Day 15 Year 1972 Hour 1:10 P. M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 38 UNIVERSITY HOSPITAL		3. DATE PRONOUNCED DEAD Month April Day 15 Year 1972 Hour 1:10 P. M.	
5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY AA		C. CITY OR TOWN Pasadena D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
6. SEX Male	7. RACE Negro	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	E. STREET AND NUMBER Box 249, Bay Side Beach Rd
9. DATE OF BIRTH 4-13-1911	10. AGE (In years last birthday) 61	11. BIRTHPLACE (State or foreign country) A.A. Co MD	12. CITIZEN OF USA COUNTRY? USA
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER		15. MOTHER'S MAIDEN NAME Jessanna Koss	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no		17. SOCIAL SECURITY NO. 212-01 9033	
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Multiple Injuries		18. INFORMANT Donna Lane ADDRESS 7100 Rte 10, Hagerstown, MD	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. ANTECEDENT CAUSES		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C)	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 4-12-72	20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) yes
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Street	22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? Hog Neck Rd. near Elizabeth Road / County A.A.	
22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.) 4-12-72 ?	22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> Un <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	22F. HOW DID INJURY OCCUR? ? Subject in auto accident	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Ronald N. Kornblum, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 4/16/72	
24A. BURIAL CREMATION, REMOVAL (Specify) Buried	24B. DATE 4/19/72	24C. NAME OF CEMETERY or CREMATORY St. John Church	24D. LOCATION (City, town, or county) (State) Pasadena MD
25A. DATE REC'D BY HEALTH DEPT APR 17 1972	25B. NAME OF REGISTRAR Robert E. Taylor	25C. FUNERAL DIRECTOR Marshall P. Hughes	ADDRESS 638 N. Highland St

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

<div style="display: flex; justify-content: space-between;"> A-421 72 03653 BALTIMORE CITY HEALTH DEPARTMENT </div> <div style="display: flex; justify-content: space-between;"> CERTIFICATE OF DEATH REG. NO. 72 03653 </div>			
BIRTH NO. 1. NAME OF DECEASED (Type or Print) HERMAN ALSBRIDGE'S		2. DATE AND HOUR OF DEATH April 15, 1972 7:35 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) University of Maryland Hospital		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE NEW YORK B. COUNTY 29 C. CITY OR TOWN BUFFALO D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 755 Bust St	
5. SEX M	6. RACE BLACK	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-14-28
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER		10B. KIND OF BUSINESS OR INDUSTRY CONSTRUCTION	9. AGE (In years last birthday) 43
11. BIRTHPLACE (State or foreign country) BALTIMORE MD		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME ELIJAH MILLS		14. MOTHER'S MAIDEN NAME SARAH ALSTON	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO.		16. SOCIAL SECURITY NO. 220-14-3410	17. INFORMANT KENNETH HAJTI
		ADDRESS 495 Sycamore Ave Buffalo N.Y.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH 4/10/9 I		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 hour	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. (A) IMMEDIATE CAUSE CARDIAC ARRHYTHMIA DUE TO, OR AS A CONSEQUENCE OF: (B) Suspected Acute Myocardial Infarction DUE TO, OR AS A CONSEQUENCE OF: - ? hours (C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
19A. DATE OF OPERATION 0	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 15 April 1972 to 15 April 1972, that (I) (we) last saw the deceased alive on 15 APRIL 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.			
23A. SIGNATURE John F. Rogers MD		23B. DATE SIGNED April 15, 1972	
23C. PHYSICIAN'S NAME (Type) JOHN F. ROGERS		23D. ADDRESS UNIVERSITY OF MARYLAND HOSPITAL	
24A. BURIAL CREMATION, REMOVAL (Specify) Removal	24B. DATE 4/17/72	24C. NAME of CEMETERY or CREMATORY Fanning Plot	24D. LOCATION (City, town, or county) (State) BUFFALO N.Y.
25A. DATE REC'D BY HEALTH DEPT. APR 17 1972		25B. NAME OF REGISTRAR Robert E. [Signature]	25C. FUNERAL DIRECTOR For Meadows Bros. Buffalo N.Y.



1. NAME OF DECEASED (Type or Print)		2. DATE OF DEATH		3. DATE PRONOUNCED DEAD		4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		5. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)	
WILLIE MASSEY		Known <input type="checkbox"/> Estimated <input type="checkbox"/>		Month Day Year Hour		Month Day Year Hour		A. STATE B. COUNTY	
FULL NAME OF HOSPITAL OR INSTITUTION		Maryland		April 13, 1972		11:15 A.M.		1303	
1202 W. North Avenue		Baltimore		D. INSIDE CITY LIMITS?		YES <input type="checkbox"/> NO <input type="checkbox"/>			
6. SEX		7. RACE		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		9. DATE OF BIRTH		10. AGE (In years lost birthday)	
Male		Negro		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8/8/10		62	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		15. MOTHER'S MAIDEN NAME	
North Carolina		U S A		???		Janitor		School	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)		17. SOCIAL SECURITY NO.		18. INFORMANT		19. CAUSE OF DEATH		20. DATE OF OPERATION	
(Yes, no or unknown)				Mrs Ruby Hasty, 2313 Eutaw Place		Hypertensive and arteriosclerotic cardiovascular disease		21. AUTOPSY? (Yes or No)	
						(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		No	
						(B) DUE TO, OR AS A CONSEQUENCE OF:			
						(C) DUE TO, OR AS A CONSEQUENCE OF:			
						OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		22D. TIME OF INJURY (Approx.)		22E. INJURY OCCURRED	
						22F. HOW DID INJURY OCCUR?			
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Charles S. Springate, M.D.		Burial		4/17/72		Mt Auburn Cemetery		Baltimore, Md	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		25D. ADDRESS			
APR 17 1972		Robert E. Taylor, M.D.		Adolphus Halstead		1206 W north A			

1802 S

STATIONERY



1

8-524 72 03655 BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 72 03655

BIRTH NO.

1. NAME OF DECEASED (Type or Print) JERAMIAH SINGLETARY		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> April 13, 1972 M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 00 2118 Callow Avenue		3. DATE PRONOUNCED DEAD Month Day Year Hour April 13, 1972 6:50 A.M.	
6. SEX Male		7. RACE Negro	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore	
9. DATE OF BIRTH 10/16/32		10. AGE (In years lost birthday) 39	
11. BIRTHPLACE (State or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY?	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Janitorial Service		14B. KIND OF BUSINESS OR INDUSTRY Janitorial Service	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO.	
18. INFORMANT Mr Howard Hill, 2418 Lakeview Ave		ADDRESS	
19. CAUSE OF DEATH E 8871 X		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE Subdural hematoma DUE TO, OR AS A CONSEQUENCE OF:	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(B) DUE TO, OR AS A CONSEQUENCE OF:	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		(C) DUE TO, OR AS A CONSEQUENCE OF:	
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIB. <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Home	
22C. WHERE DID IT IN BALTIMORE CITY, GIVE EXACT LOCATION? 2118 Callow Avenue		22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.) 4-13-72 3:00 A. m.	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? Presumably accidentally fell	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Charles S. Springate M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Charles S. Springate, M.D.		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4/18/72	
24C. NAME OF CEMETERY or CREMATORY MT Auburn Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, M.	
25A. DATE REC'D BY HEALTH DEPT. APR 17 1972		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.	
25C. FUNERAL DIRECTOR Adolphus Halstead		25D. ADDRESS 1206 W North Ave	

VS 151-REV. 7/1/68

2000 ST

2000 ST

2000 ST

2000 ST

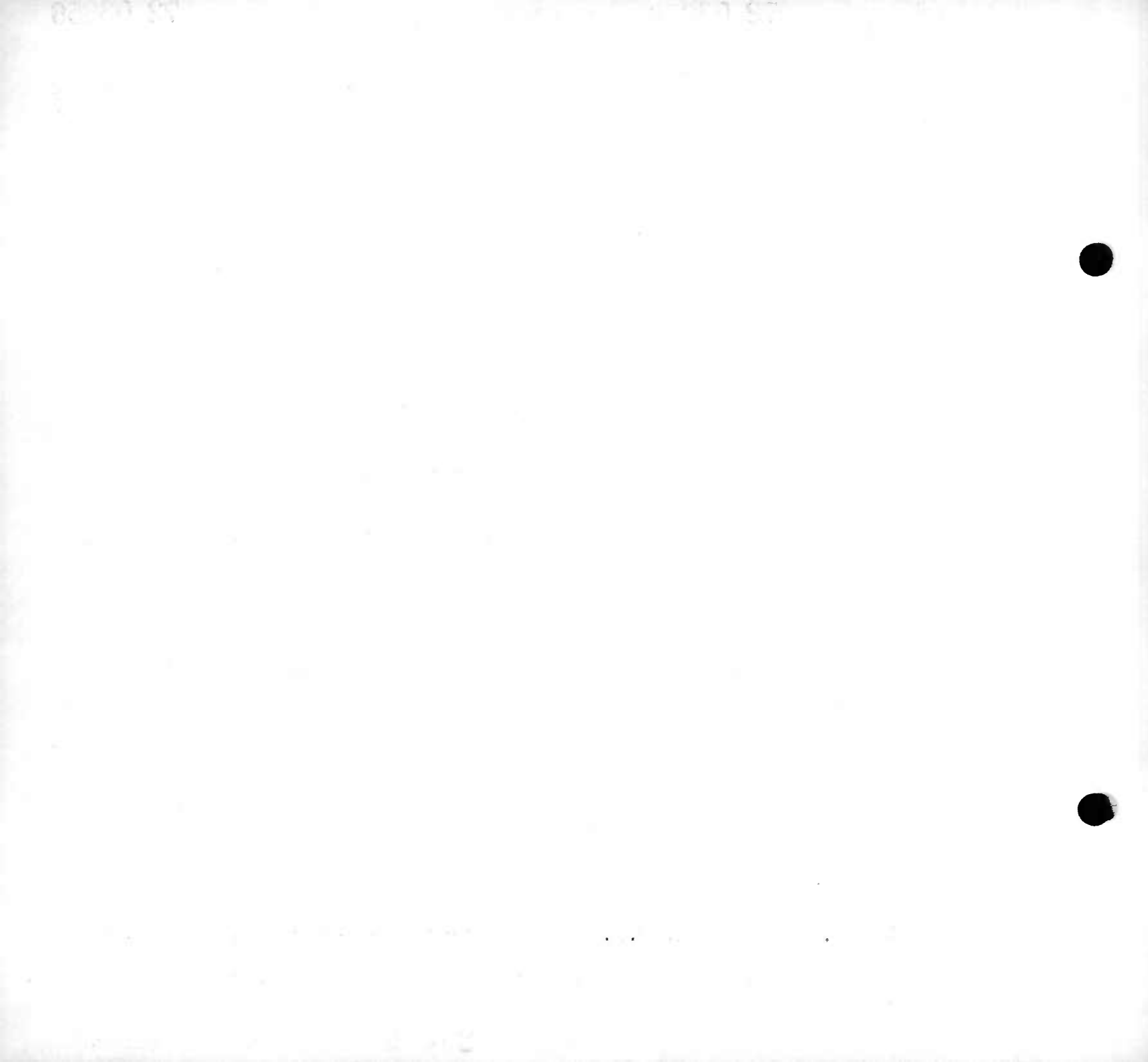
2000 ST



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

K-160		72 03656		BALTIMORE CITY HEALTH DEPARTMENT		72 03656	
BIRTH NO.				REG. NO.			
1. NAME OF DECEASED (Type or Print) <u>Riviere, Ernest</u>				2. DATE AND HOUR OF DEATH <u>4-9-72</u> <u>11:15</u> <u>4</u> M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MD.</u> B. COUNTY <u>703</u>			
FULL NAME OF HOSPITAL OR INSTITUTION <u>Harbor View Nursing Home</u>				C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				E. STREET AND NUMBER <u>2226 Madison ST.</u>			
5. SEX <u>Male</u>	6. RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1/1/1900</u>	9. AGE (In years last birthday) <u>72</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Chief on Ship</u>			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Virgin Islands</u>		
13. FATHER'S NAME <u>Unknown</u>			14. MOTHER'S MAIDEN NAME <u>Unknown</u>		12. CITIZEN OF WHAT COUNTRY?		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT <u>Chart</u>		
18. <u>153.31</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Intestinal Hemorrhage</u> (B) <u>Carcinoma of the Sigmoid Colon</u> (C) _____			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>6 Weeks</u> <u>2 Years</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <u>Carcinoma of Prostate with Bone Metastases</u>						<u>2 Years</u>	
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>25 February</u> 19 <u>72</u> to <u>9 April</u> 19 <u>72</u> that (I) (we) last saw the deceased alive on <u>9 April</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>Peter H. Rhoinstein, M.D.</u>				23B. DATE SIGNED <u>10 April 1972</u>			
23C. PHYSICIAN'S NAME (Type) <u>Peter H. Rhoinstein, M.D.</u>				23D. ADDRESS <u>Harbor View Convalescent Center</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>4/17/72</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Mt Calvary Cemetery</u>		24D. LOCATION (City, town, or county) (State) <u>A A County Md</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>APR 17 1972</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor, M.D.</u>		25C. FUNERAL DIRECTOR <u>346 Halstead</u>		ADDRESS <u>1206 W 14th Ave</u>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				CERTIFICATE OF DEATH		REG. NO. <u>72 03657</u>	
T-520 BIRTH NO. <u>72 03657</u> 1. NAME OF DECEASED (Type or Print) <u>Harvey, Thomas</u>				2. DATE AND HOUR OF DEATH <u>2:10 April 14 1972</u> M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <u>Provident Hospital</u>				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>1505</u>			
FULL NAME OF HOSPITAL OR INSTITUTION <u>Provident Hospital</u> IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION				C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
CERTIFICATE AMENDED <u>39</u> <u>4-20-72</u>				E. STREET AND NUMBER <u>2609 Reisterstown Road</u>			
5. SEX <u>Male</u>	6. RACE <u>Black</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-3-49</u>	9. AGE (In years last birthday) <u>32</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Oriole General Cleaning Services, Inc.</u>			10B. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
13. FATHER'S NAME <u>Thomas Harvey</u>			14. MOTHER'S MAIDEN NAME <u>Agnes</u>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO. <u>213-36-6599</u>		17. INFORMANT <u>Norma Harvey (wife)</u>		ADDRESS <u>Same</u>
18. <u>412.21</u> CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) IMMEDIATE CAUSE <u>CVA</u> DUE TO, OR AS A CONSEQUENCE OF: <u>Hypertensive Cardio Vascular</u> (B) DUE TO, OR AS A CONSEQUENCE OF: <u>disease</u> (C) _____			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>few hrs.</u>
II							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>2:10 April 14 1972</u> to <u>2:39 April 14 1972</u> that (I) (we) last saw the deceased alive on <u>April 14, 1972</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>Manuel Mercado</u>				DEGREE Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) <u>M. C. MERCADO</u>				23D. ADDRESS <u>PROVIDENT HOSP. BALTO. Md. 21204</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>4/17/72</u>		24C. NAME OF CEMETERY or CREMATORY <u>MT Auburn Cemetery</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>APR 17 1972</u>		25B. NAME OF REGISTRAR <u>Robert E. Halstead</u>		25C. FUNERAL DIRECTOR <u>3088</u>		ADDRESS <u>1206 W North Ave</u>	

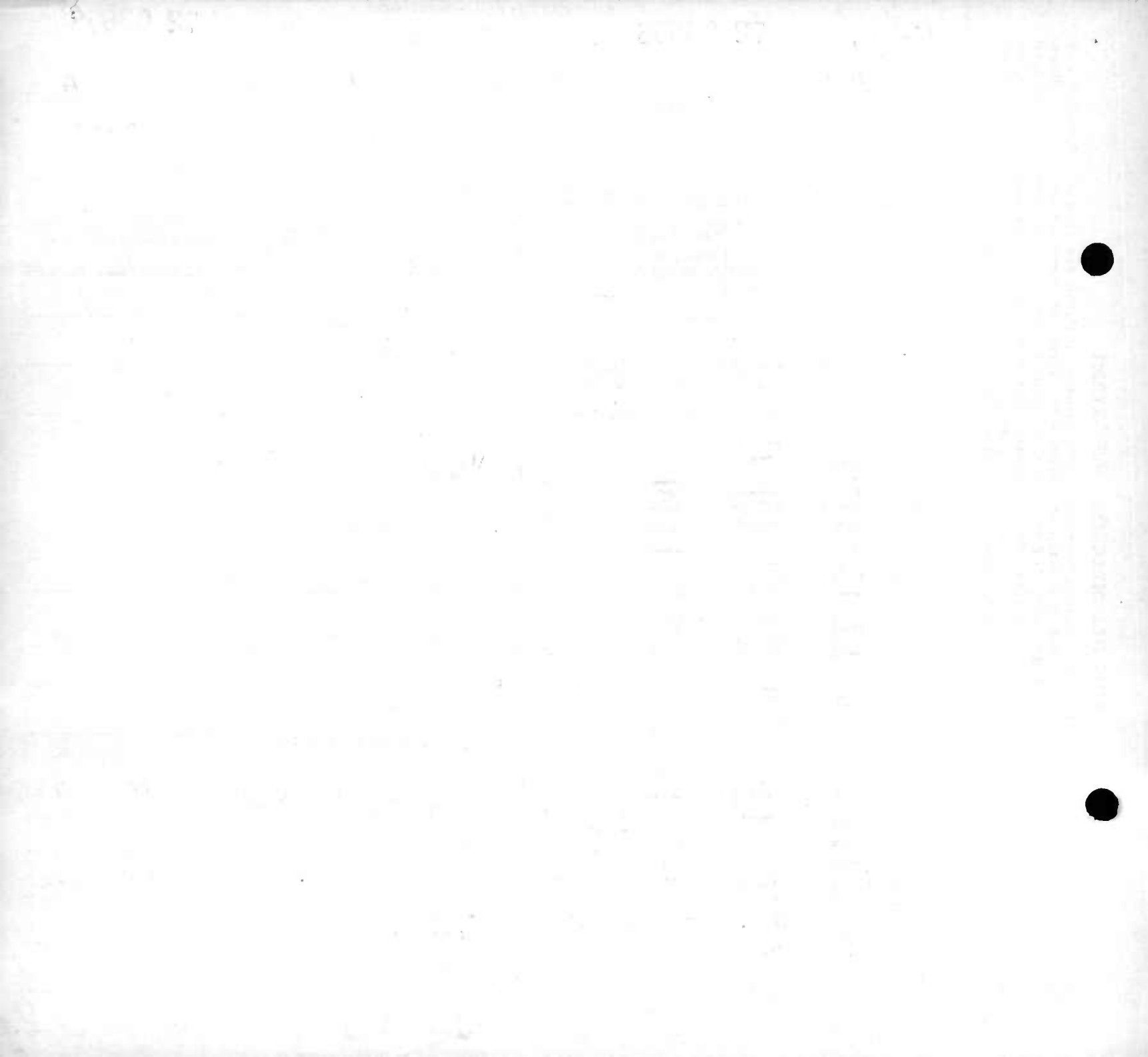
4-20-1972 - Item #8 - Verification from Birth Certificate F-00421 - born 9-3-39.
Item 4-E - Affidavit of Wife Mrs. Norma Harvey.

HRS

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <u>M-324</u>				BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>72 03658</u>			
1. NAME OF DECEASED (Type or Print) <u>MITCHELL (RETHA) Macregher</u>				2. DATE AND HOUR OF DEATH <u>6:55 4-14-72</u>				A. M. <u>A</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission)				A. STATE <u>Maryland</u>			
FULL NAME OF HOSPITAL OR INSTITUTION <u>33 The Johns Hopkins Hospital</u>				B. COUNTY <u>805</u>				C. CITY OR TOWN <u>Baltimore</u>			
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				E. STREET AND NUMBER <u>1645 Darley Avenue</u>			
5. SEX <u>Female</u>		6. RACE <u>Negro</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <u>Sept. 24 1929</u>		9. AGE (In years last birthday) <u>42</u>		If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10B. KIND OF BUSINESS OR INDUSTRY <u>-</u>				11. BIRTHPLACE (State or foreign country) <u>S. Carolina</u>			
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13. FATHER'S NAME <u>John Mc Kinney</u>				14. MOTHER'S MAIDEN NAME <u>Hattie Timmons</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO.				17. INFORMANT <u>William Cumber</u>			
ADDRESS <u>1645 Darley Ave</u>				18. CAUSE OF DEATH <u>Cirrhosis of the liver</u>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Hepatic + Renal Failure</u>				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:							
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Chronic Alcoholism</u>				(B) DUE TO, OR AS A CONSEQUENCE OF:							
(C) DUE TO, OR AS A CONSEQUENCE OF:											
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).											
19A. DATE OF OPERATION <u>0</u>				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED				20A. AUTOPSY? (Yes or No) <u>NO</u>			
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?											
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>19</u> to <u>April 14</u> 19 <u>72</u> that (I) (we) last saw the deceased alive on <u>April 14</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.											
23A. SIGNATURE <u>John A. Nesbitt, Jr.</u>				23B. DATE SIGNED <u>April 14, 1972</u>							
23C. PHYSICIAN'S NAME (Type) <u>John A. Nesbitt, MD</u>				23D. ADDRESS <u>Johns Hopkins Hospital 601 N. Broadway</u>							
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>				24B. DATE <u>4-19-72</u>				24C. NAME of CEMETERY or CREMATORY <u>Arlington Memorial Park</u>			
24D. LOCATION <u>Arlington, Md.</u>				25A. DATE REC'D BY HEALTH DEPT. <u>APR 17 1972</u>				25B. NAME OF REGISTRAR <u>Robert J. ...</u>			
25C. FUNERAL DIRECTOR <u>Miller & Kysickson</u>				ADDRESS <u>1129 N. Caroline St.</u>							



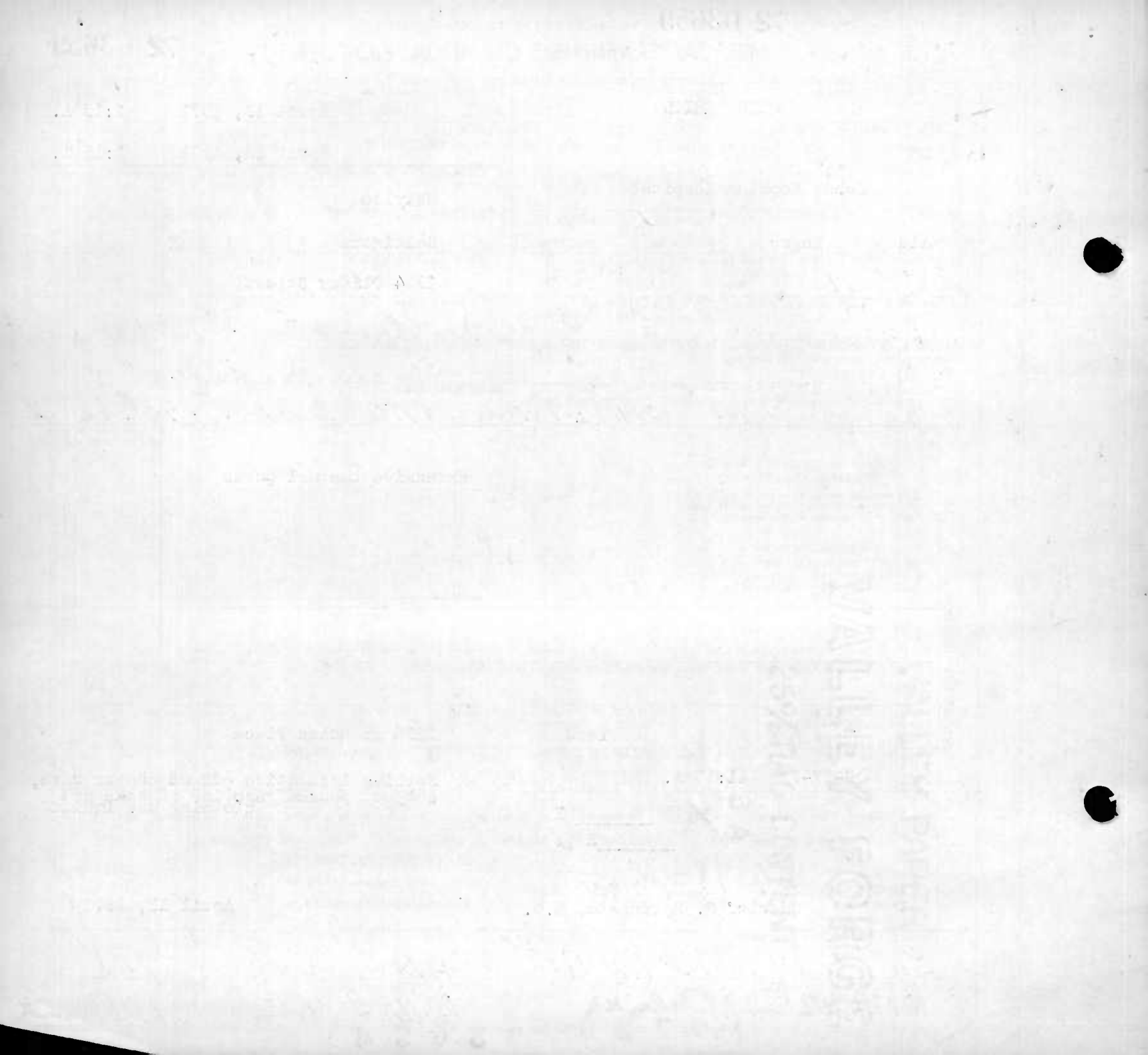
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

72 03659

BIRTH NO.

REG. NO.

1. NAME OF DECEASED (Type or Print) OTIS SMITH		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> April 13, 1972		Hour 2:15 A. M.
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 33 Johns Hopkins Hospital		3. DATE PRONOUNCED DEAD Month Day Year April 13, 1972		Hour 2:15 A. M.
6. SEX Male		7. RACE Negro		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
9. DATE OF BIRTH Oct 27, 1927		10. AGE (In years last birthday) 44		11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF U.S.A.		13. FATHER'S NAME William C. Smith		14. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 804
15. MOTHER'S MAIDEN NAME Alice Holmes		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) Yes W.W.II.		17. SOCIAL SECURITY NO. 214-22-7583
18. INFORMANT Lillie Mae Smith		19. CAUSE OF DEATH Extensive thermal burns		20. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
21. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) Extensive thermal burns		22. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		23. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).
20A. DATE OF OPERATION 0		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) No
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Yard		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? 2230 Prentiss Place
22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.) 3-27-72 11:15 A.		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? Burning insulation off of copper wire, subject poured gasoline on same and clothing was ignited
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		24. ACTUAL SIGNATURE Charles S. Springate M.D.		25. DATE SIGNED April 13, 1972
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4-18-72		24C. NAME OF CEMETERY or CREMATORY Md. National Memorial
24D. LOCATION (City, town, or county) (State) Frederick, Md.		25A. DATE REC'D BY HEALTH DEPT. APR 17 1972		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.
25C. FUNERAL DIRECTOR Walter E. Eickman		25D. ADDRESS 1129 N. Central		



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 03660	
BIRTH NO. 72 03660				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) DeShield, LUTHER EARL			2. DATE AND HOUR OF DEATH 4/15/72 5:20 P.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION NORTH CHARLES GEN. HOSP.			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY 1303 C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 2321 McCulloh Street		
5. SEX MALE	6. RACE NEGRO	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-12-99		9. AGE (In years last birthday) 72
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Changeover		10B. KIND OF BUSINESS OR INDUSTRY Put. Family		11. BIRTHPLACE (State or foreign country) Thaskin, Md.	
13. FATHER'S NAME ZORAH DeShield			14. MOTHER'S MAIDEN NAME Julia NUTTER		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) yes World War I			16. SOCIAL SECURITY NO. 218-05-2429		
17. INFORMANT Miss Tyree DeShield			ADDRESS 2321 McCulloh St.		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) Cardiac arrest			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 hrs.		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Heart block & arteriosclerosis 15 years			(B) DUE TO, OR AS A CONSEQUENCE OF: Dissecting aortic aneurysm 15 years		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION 4/15/72		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 4/15 19 72 to 4/15 19 72 , that (I) (we) last saw the deceased alive on 4/15 19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Veena Sathirapal M.D.				23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) VEENA SATHIRAPAL M.D.				23D. ADDRESS NORTH CHARLES GEN HOSP	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4-20-72		24C. NAME OF CEMETERY or CREMATORY Family Lot	
24D. LOCATION (City, town, or county) (State) Tyaskin Maryland		25A. DATE REC'D BY HEALTH DEPT. APR 17 1972			
25B. NAME OF FUNERAL HOME NUTTER FUNERAL HOME		25C. FUNERAL DIRECTOR ADDRESS 3035 W. NORTH AVE			

3000 1000 1000 1000 1000 1000 1000 1000 1000 1000

1000 1000 1000 1000 1000 1000 1000 1000 1000 1000

1000 1000 1000 1000 1000 1000 1000 1000 1000 1000

1000 1000 1000 1000 1000 1000 1000 1000 1000 1000

1000 1000 1000 1000 1000 1000 1000 1000 1000 1000

1000 1000 1000 1000 1000 1000 1000 1000 1000 1000

1000 1000 1000 1000 1000 1000 1000 1000 1000 1000

1000 1000 1000 1000 1000 1000 1000 1000 1000 1000

1000 1000 1000 1000 1000 1000 1000 1000 1000 1000

1000 1000 1000 1000 1000 1000 1000 1000 1000 1000

1000 1000 1000 1000 1000 1000 1000 1000 1000 1000

1000 1000 1000 1000 1000 1000 1000 1000 1000 1000

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 03661	
72 03661			
BIRTH NO.		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) SOLOMON Crosby		2. DATE AND HOUR OF DEATH 4/14/72 7-40 P M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD Lutheran Hosp.		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MD B. COUNTY 1502	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Lutheran Hosp.		C. CITY OR TOWN BALTO D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER 1408-N. Bruce, St			
5. SEX Male	6. RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-15-04
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) salvage man		9. AGE (In years last birthday) 68	
10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Soloman Crosby		12. CITIZEN OF WHAT COUNTRY? USA	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		14. MOTHER'S MAIDEN NAME Emma ?	
16. SOCIAL SECURITY NO. 218-05-2429		17. INFORMANT Mrs. Thelma Sampson	
		ADDRESS 1426 N. School St.	
18. CAUSE OF DEATH 410.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION 4/10/72		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I certify that the (this hospital) attended the deceased from 4/14/72 to 4/14/72 that it (we) last saw the deceased alive on 19 and that in (our) opinion death occurred on the date and hour and from the causes stated above, it (We) (did) (did not) view the body after death.			
23A. SIGNATURE SEIN LWIN		23B. DATE SIGNED 4/14/72	
23C. PHYSICIAN'S NAME (Type) SEIN LWIN		23D. ADDRESS LUTHERAN HOSPITAL	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4-19-72	
24C. NAME OF CEMETERY or CREMATORY Mt. Auburn Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore Maryland	
25A. DATE REC'D BY HEALTH DEPT. APR 17 1972		25B. NAME OF REGISTRAR Robert E. Taylor, MD	
25C. FUNERAL DIRECTOR NUTTER FUNERAL HOME		ADDRESS 3035 W. NORTH AVE	

2-12-6-1-7

2-12-6-1-7

2-12-6-1-7

FUNERAL DIRECTOR: IMPORTANT

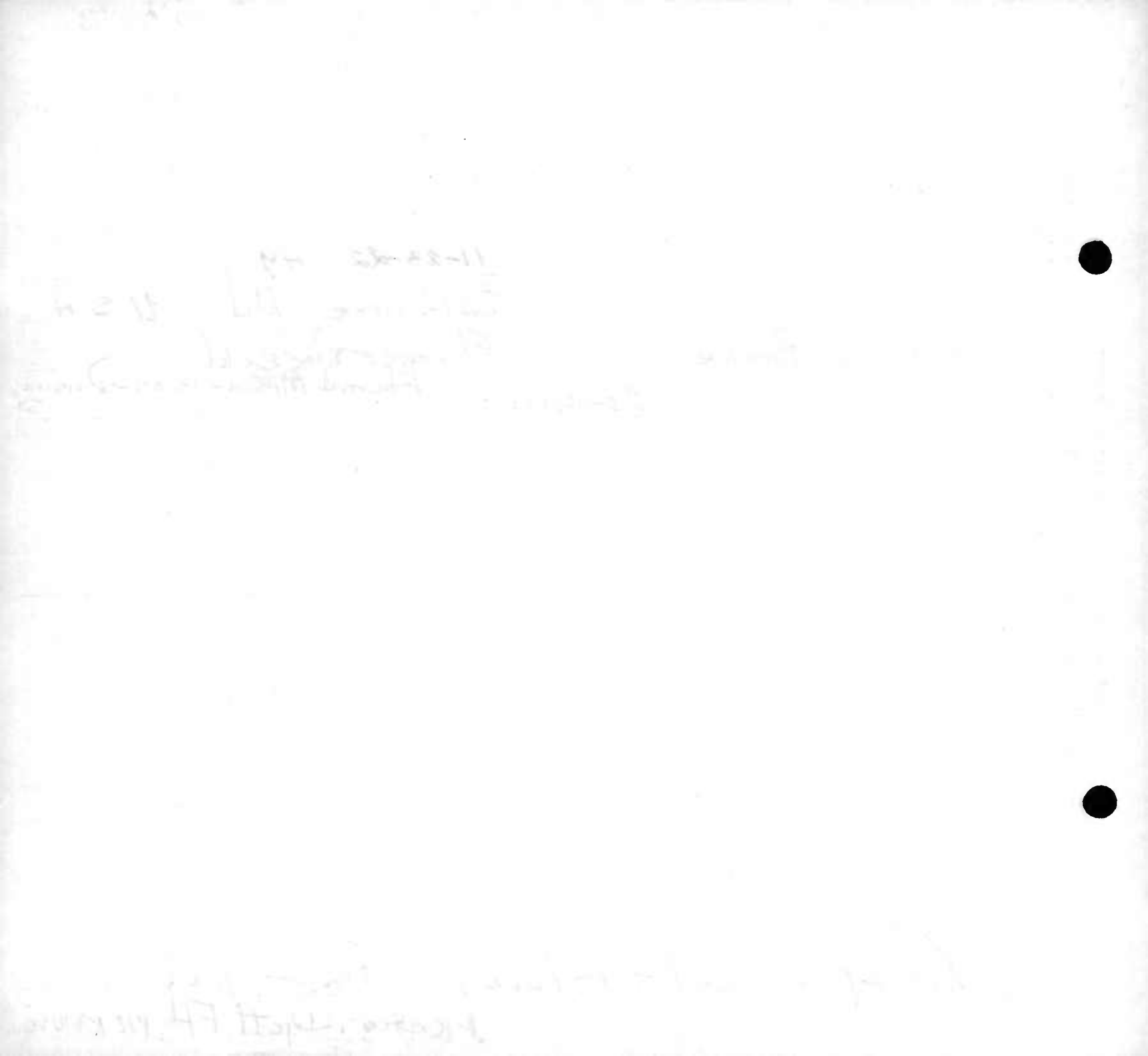
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

W32572 03662		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 03662	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) MARIE DORSEY (WATSON)		2. DATE AND HOUR OF DEATH 4-16-72 7:10 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD MARYLAND GEN. Hosp.		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MD B. COUNTY 1602		C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
FULL NAME OF HOSPITAL OR INSTITUTION MARYLAND GEN. Hosp.		E. STREET AND NUMBER 1100 N. STRICKER #17			
5. SEX F	6. RACE N	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-6-96	9. AGE (In years last birthday) 75	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Nm		10B. KIND OF BUSINESS OR INDUSTRY Nm		11. BIRTHPLACE (State or foreign country) Washington D.C.	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME WILLIAM DORSEY		14. MOTHER'S MAIDEN NAME MARY	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) [If yes, give war or dates of service] no		16. SOCIAL SECURITY NO.		17. INFORMANT CATHERINE WASHINGTON	
ADDRESS 1100 N. Stricker #17					
18. 4/12/72 CAUSE OF DEATH		DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 yr	
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: congestive heart failure			
ANTECEDENT CAUSES		(B) arteriosclerotic cardiac disease DUE TO, OR AS A CONSEQUENCE OF: Disease			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 4-16-72 19 72 to 4-16-72 19 72 that (I) (we) last saw the deceased alive on 4-16-72 19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE D. Melencio		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 4-16-72	
23C. PHYSICIAN'S NAME (Type) DR MELENICIO XENOTURK		23D. ADDRESS 2404 EASTRIDGE Rd - Tringum Md			
24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE 4-20-72	24C. NAME OF CEMETERY OR CREMATORY Ht. Auburn Cem. Balt., Md.		24D. LOCATION (City, town, or county) (State) 21093 St	
25A. DATE REC'D BY HEALTH DEPT. APR 17 1972		25B. NAME OF REGISTRAR Robert E. Barber, R.D.		25C. FUNERAL DIRECTOR Walter + Ruth F. H 1701 - Lanes	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				CERTIFICATE OF DEATH		REG. NO. <u>72 03663</u>	
BIRTH NO. <u>72 03663</u>		1. NAME OF DECEASED (Type or Print) <u>HILDA MASON</u>		2. DATE AND HOUR OF DEATH <u>4-14-72</u> <u>4:40 P. M.</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>MARYLAND GENERAL HOSPITAL</u> <u>48</u>				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MD</u> B. COUNTY <u>DALTON</u> <u>1702</u>			
5. SEX <u>F</u>		6. RACE <u>N N</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>11-23-22</u>	
9. AGE (in years lost birthdy) <u>49</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11. BIRTHPLACE (State or foreign country) <u>Baltimore Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>James Boone</u>				14. MOTHER'S MAIDEN NAME <u>Florence Ringgold</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>213-18-6855</u>		17. INFORMANT <u>Hilda Mason - 1339 Division St</u>		ADDRESS <u>HUSBAND'S FAMILY</u>	
18. <u>43101</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>PROBABLE</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CAUSE last. <u>II</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). (A) IMMEDIATE CAUSE <u>INTRACEREBRAL HEMORRHAGE</u> DUE TO, OR AS A CONSEQUENCE OF: <u>48 hrs</u> (B) <u>HYPERTENSION</u> DUE TO, OR AS A CONSEQUENCE OF: (C) _____				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>NO</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>4/12</u> 19 <u>72</u> to <u>4/14</u> 19 <u>72</u> that (I) (we) last saw the deceased alive on <u>4/14</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>Michael J. Faulstich MD</u>				23B. DATE SIGNED <u>4/14/72</u>		23C. PHYSICIAN'S NAME (Type) <u>Michael J. Faulstich MD</u>	
23D. ADDRESS _____		23E. DEGREE _____		23F. MED. DIRECTOR <input type="checkbox"/>		23G. STAFF PHYS. <input checked="" type="checkbox"/>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>4-17-72</u>		24C. NAME OF CEMETERY or CREMATORY <u>Mt. Auburn</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore, Md</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>APR 17 1972</u>		25B. NAME OF REGISTRAR <u>James E. Gabe</u>		25C. FUNERAL DIRECTOR <u>Walter F. H</u>		ADDRESS <u>1701 W. 1st</u>	



11-22-11
11-22-11
11-22-11
11-22-11
11-22-11

11-22-11
11-22-11
11-22-11
11-22-11
11-22-11

F 630

72 03664

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 72 03664

BIRTH NO.

1. NAME OF DECEASED
(Type or Print) JULIA FAHERTY2. DATE OF DEATH Known ☐ Month Day Year Hour
Estimated ☐ M.4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD
FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)
OR INSTITUTION3. DATE PRONOUNCED DEAD Month Day Year Hour
April 16, 1972 4:10 A. M.5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)
A. STATE Maryland B. COUNTY 103

6. SEX

Female

7. RACE

White

8. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☐ NO ☐

9. DATE OF BIRTH

9 Feb 1917

10. AGE (in years
last birthday)

56

11. Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

11. BIRTHPLACE (State or foreign country)

Baltimore, Md

12. CITIZEN OF
WHAT COUNTRY?

Baltimore, Md

13. FATHER'S NAME

Joseph P. Faherty

14. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Unemployed

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

Catherine Lynch

16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

17. SOCIAL SECURITY NO.

215-01-3871

18. INFORMANT

ADDRESS

Mrs Doris Knapp, 2507 Eastern Ave, Balto Md

19.

2880X

CAUSE OF DEATH

Craniocerebral Injuries

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART 1 (A).

MEDICAL CERTIFICATION

20A. DATE OF OPERATION

2

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

yes

22A. EXTERNAL CAUSE WAS
UNDERLYING ☒ OR CONTRIB-
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg., etc.)

Home

22C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?

2507 Eastern Avenue 103

22D. TIME (Month) (Day) (Year) (Hour)
OF INJURY (APPROX.) 4-11-72 10:25 P.

22E. INJURY OCCURRED.

WHILE AT
WORK ☐NOT WHILE
AT WORK ☒

22F. HOW DID INJURY OCCUR?

Fell down steps

23.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE

EXAMINER'S NAME (Type) Ronald N. Kornblum, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

4/16/72

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

20 Apr 72

24C. NAME of CEMETERY or CREMATORY

New Cathedral Cemetery

24D. LOCATION (City, town, or county) (State)

4300 Old Frederick Rd Balto, Md

25A. DATE REC'D BY HEALTH DEPT.

APR 17 1972

25B. NAME OF REGISTRAR

Robert E. Fahey, M.D.

25C. FUNERAL DIRECTOR

ADDRESS

LILLY & ZIELER INC, 1901 Eastern Ave
Balto, Md.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

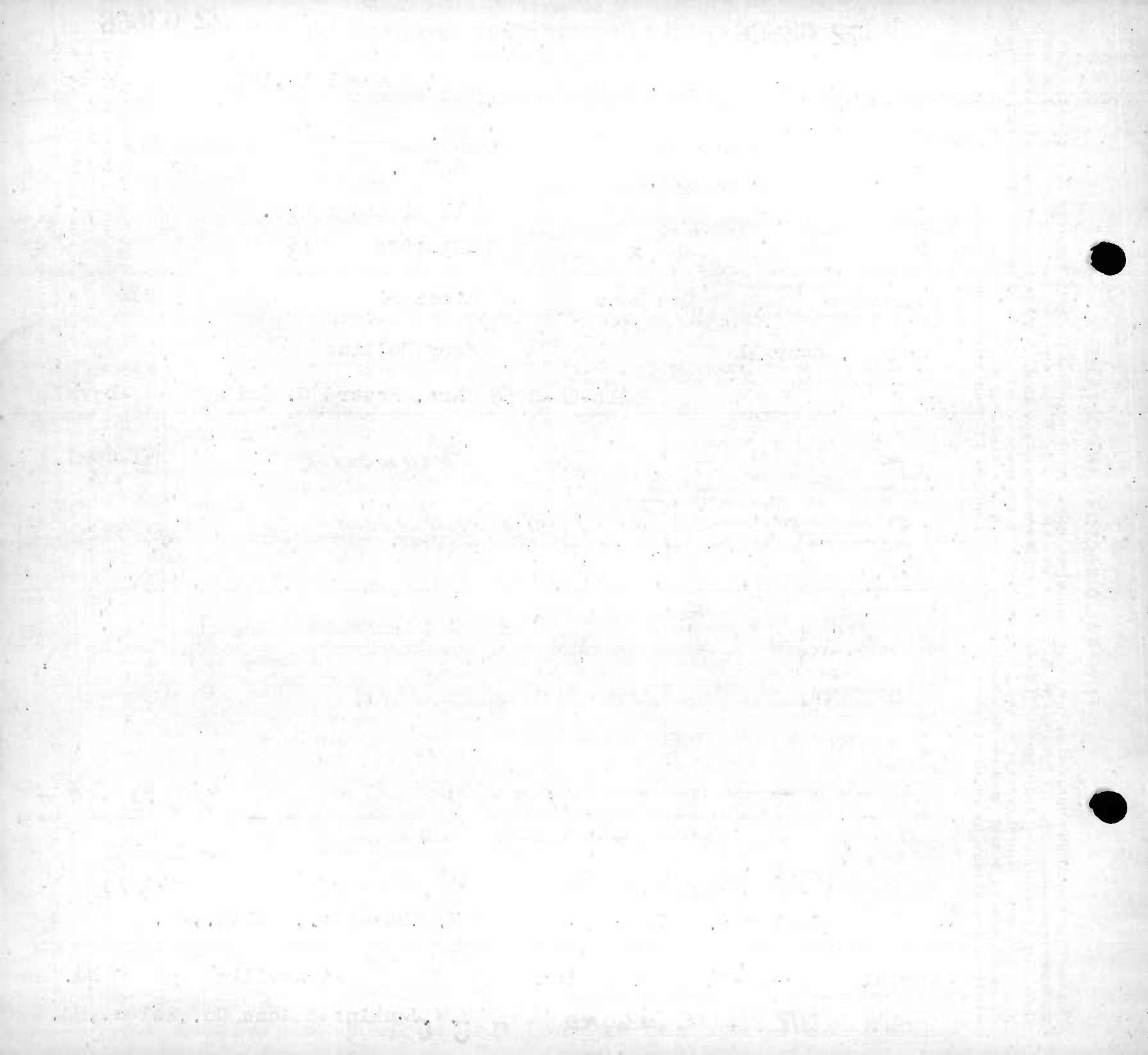
1. NAME OF DECEASED (Type or Print) MARY E. HOFFMAN		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 31 BALTIMORE CITY HOSPITAL		3. DATE PRONOUNCED DEAD Month Day Year Hour April 14, 1972 11:30 A.	
5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 2605		6. SEX Female 7. RACE White 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH 9 March 1889		10. AGE (In years lost birthday) 83	
11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		15. MOTHER'S MAIDEN NAME Un-known	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		17. SOCIAL SECURITY NO. None	
18. INFORMANT John W. Hoffman Jr.		ADDRESS 7830 Gough St, Balto, Md	
19. 412.4 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease		CAUSE OF DEATH APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:	
		(B) DUE TO, OR AS A CONSEQUENCE OF:	
		(C) DUE TO, OR AS A CONSEQUENCE OF:	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIB-UTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22D. TIME (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?		21. AUTOPSY? (Yes or No) no	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Ronald N. Kornblum, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 4/15/72	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 17 Apr 72	
24C. NAME of CEMETERY or CREMATORY Sacred Heart of Jesus		24D. LOCATION (City, town, or county) (State) German Hill Rd, Balto, Md.	
25A. DATE REC'D BY HEALTH DEPT. APR 17 1972		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.	
25C. FUNERAL DIRECTOR LILLY & ZIELER INC, 1901 Eastern Ave		ADDRESS Balto, Md.	

22/11/11

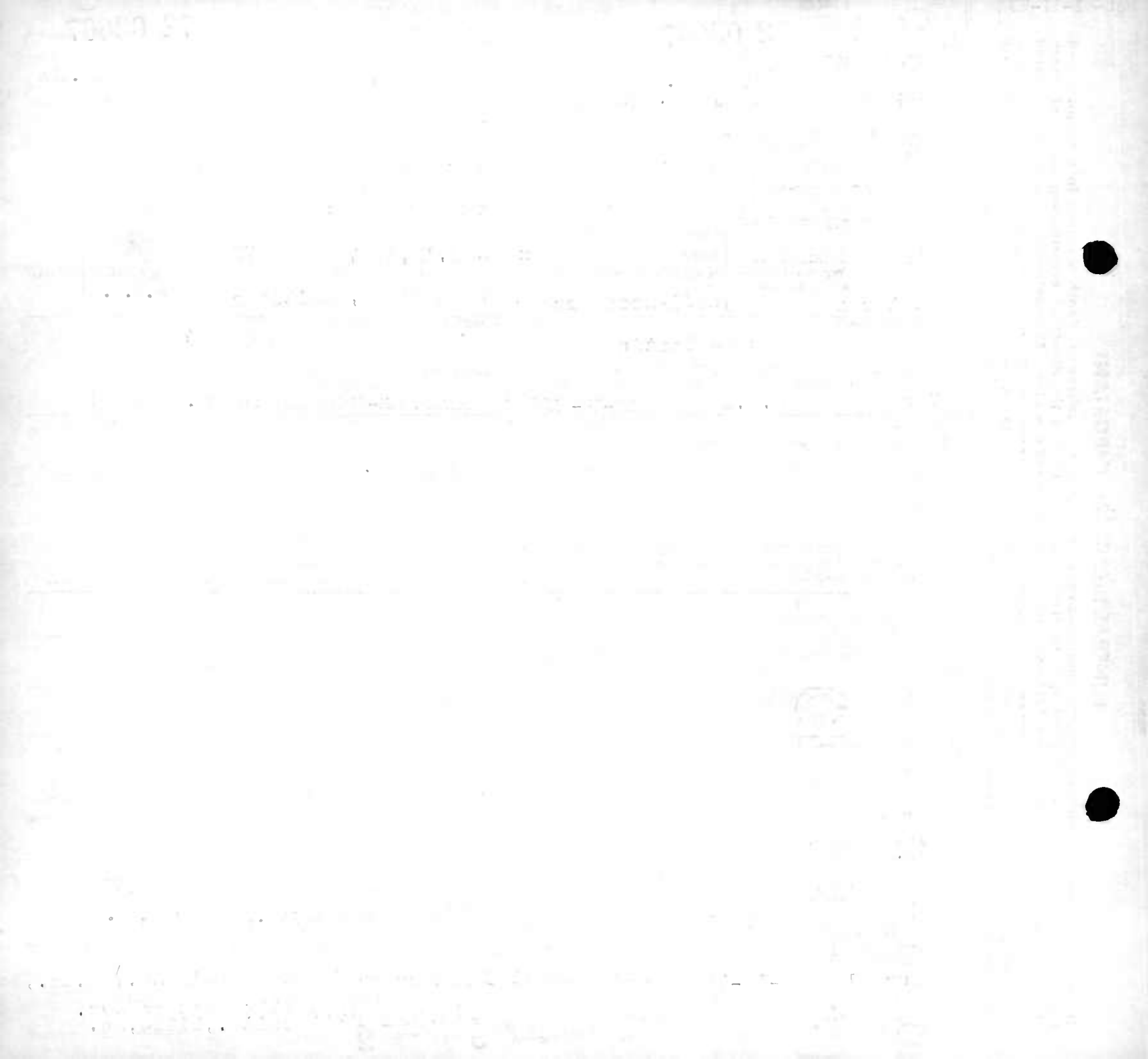
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 03666	
72 03666				CERTIFICATE OF DEATH	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		FLORENCE O. BURNAM		April 15, 1972 1:30 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 00 11 Gittings Ave.			A. STATE Md.		
			B. COUNTY Balto.		
			C. CITY OR TOWN		D. INSIDE CITY LIMITS?
			11 Gittings Ave.		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
5. SEX			6. RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
F			W		WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH			9. AGE (In years last birthday)		If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
4-23-1878			93		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)
Housewife			Own Home		Missouri
12. CITIZEN OF WHAT COUNTRY?			USA		
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
John H. Overall			Mary Rollins		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT
no			216-24-0055		Mrs. Howard C. Smith
18. 440.91			CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		3 days
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)			Pneumonia		
ANTECEDENT CAUSES			(B) Arteriosclerosis		years
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(C) _____		
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
				No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If In Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
(Month) (Day) (Year) (Hour)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from 4/5/72 19 to 4/15/72 19, that (I) (we) last saw the deceased alive on 4/14/72 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
Chas. W. Wainwright MD				4/15/72	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
Charles W. Wainwright MD				9 E. Chase St., Balto., Md.	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY	
Burial		4-17-72		Druid Ridge	
24D. LOCATION (City, town, or county)		24E. DATE REC'D BY HEALTH DEPT.		24F. NAME OF REGISTRAR	
Pikesville Md.		APR 17 1972		H. W. Jenkins & Sons Co., Balto., Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
APR 17 1972		H. W. Jenkins & Sons Co., Balto., Md.		ADDRESS	



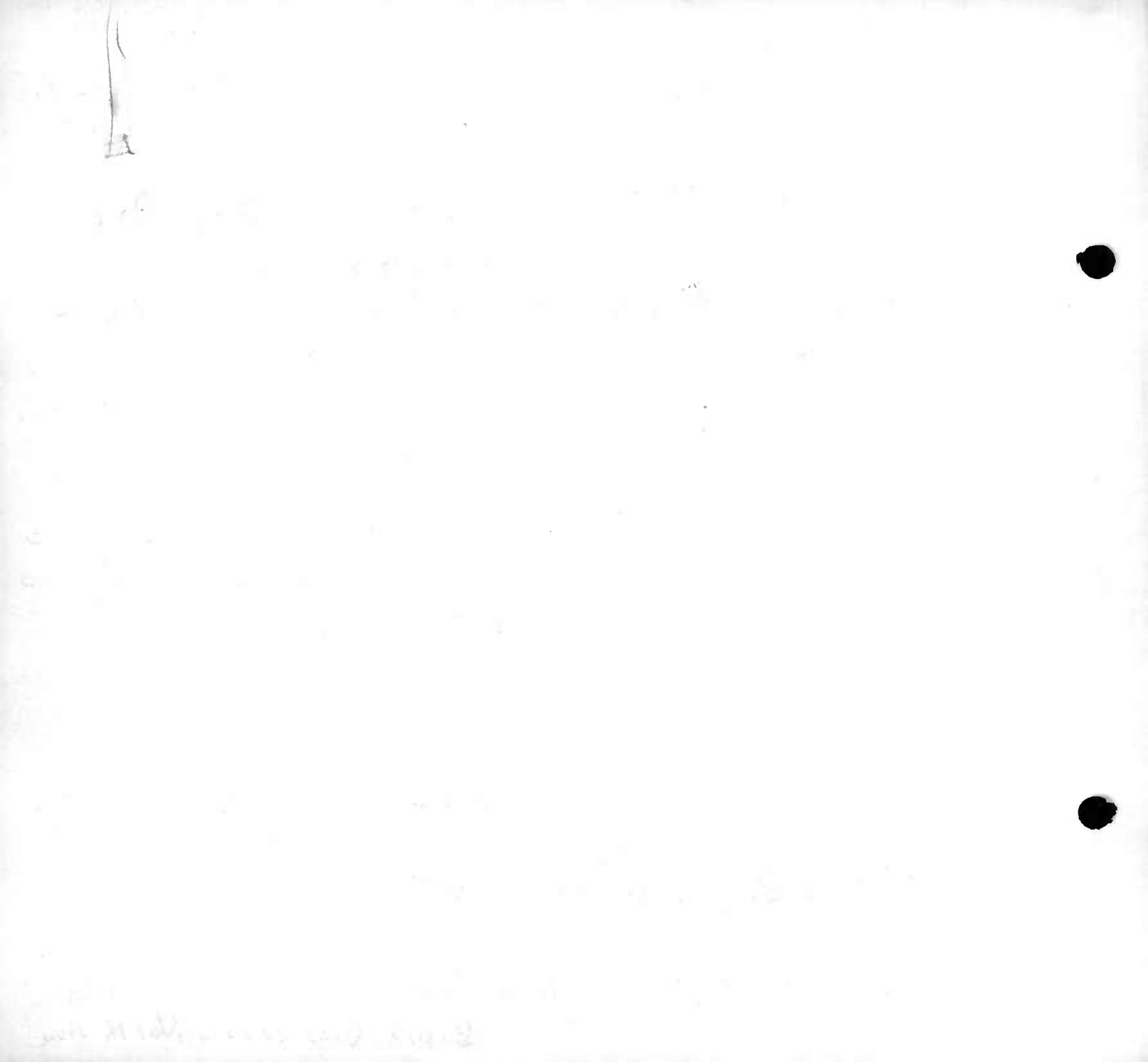
B-350 72 03667				BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 03667	
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH			
William L. Beatin				4-16-1972 12:29A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				A. STATE B. COUNTY			
31 Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland 21224				Maryland 2605			
C. CITY OR TOWN				D. INSIDE CITY LIMITS?			
Baltimore				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
E. STREET AND NUMBER				21224			
422 Drew Street				21224			
5. SEX		6. RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH	
Male		Caucasian		WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		Apr. 13, 1897	
9. AGE (In years last birthday)		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
75		Retired		Maryland, Baltimore		U.S.A.	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Angus Beatin				Mary ?			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
Yes W.W.I				214-20-4139		Records: BCH-4940 Eastern Ave. 21224	
18. CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				Respiratory Arrest			
ANTECEDENT CAUSES				(B) DUE TO, OR AS A CONSEQUENCE OF:			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				Pulmonary Edema			
II				(C) Myocardial Infarction			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
3/4/16		Pulmonary Edema		Yes			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH Indefinite medical examination		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
(Month) (Day) (Year) (Hour)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					
22. I certify that (I) (this hospital) attended the deceased from 4/15 19 72 to 4/16 19 72 that (I) (we) last saw the deceased alive on 4/16 19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE				23B. DATE SIGNED			
Robert Allan Rizza M.D. DEGREE				4/16/72			
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
Robert Allan Rizza DEGREE				4940 Eastern Ave., Baltimore, Md. Baltimore City Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial		4-19-72		Sacred Heart Cemetery		7401 German Hill Rd., Ba. Co., Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
APR 17 1972		Robert E. Galt		Charles S. Galt		6224 Eastern Ave. Balto., 21224, Md.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. <u>72 03668</u>
BIRTH NO. <u>J-525 72 03668</u>		1. NAME OF DECEASED (Type or Print) <u>Nelson A. Johnson</u>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <u>Lutheran Hosp</u>		2. DATE AND HOUR OF DEATH <u>4-10-72 12:30 P.M.</u>		
FULL NAME OF HOSPITAL OR INSTITUTION <u>Lutheran Hosp</u>		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>2047</u>		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
5. SEX <u>M</u>		6. RACE <u>C</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Social Security</u>		8. DATE OF BIRTH <u>May 8, 1914</u>
13. FATHER'S NAME <u>John A. Johnson</u>		14. MOTHER'S MAIDEN NAME <u>Maggie Williams</u>		9. AGE (in years last birthday) <u>57</u>
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		11. BIRTHPLACE (State or foreign country) <u>Baltimore Md</u>
17. INFORMANT <u>Mrs Evelyn Johnson</u>		ADDRESS <u>20 N. Monastery Ave</u>		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <u>4-10-72 12:30 P.M.</u>		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Acute myocardial infarction</u> (B) <u>Generalized atherosclerosis</u> DUE TO, OR AS A CONSEQUENCE OF: <u>Essential hypertension</u> (C) <u>Diabetes mellitus</u>		
19. DATE OF OPERATION <u>6</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		
21F. HOW DID INJURY OCCUR?		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
22. I certify that (I) (this hospital) attended the deceased from <u>1962</u> to <u>4-10-1972</u> that (I) (we) last saw the deceased alive on <u>19</u> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <u>Charles R. Venter, MD</u>				23B. DATE SIGNED
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <u>Apr 14 1972</u>		
24C. NAME OF CEMETERY OR CREMATORY <u>Arbutus Mem Park</u>		24D. LOCATION (City, town, or county) (State) <u>Arbutus Md</u>		
25A. DATE REC'D BY HEALTH DEPT. <u>APR 17 1972</u>		25B. NAME OF REGISTRAR <u>Robert E. Jones, Jr.</u>		
25C. FUNERAL DIRECTOR <u>Joseph H. Jones</u>		ADDRESS <u>2222 W. North Ave</u>		



1
B. 652
W-425 72 03669 BALTIMORE CITY HEALTH DEPARTMENT
MEDICAL EXAMINER'S CERTIFICATE OF DEATH REG. NO. 72 03669

BIRTH NO.

1. NAME OF DECEASED (Type or Print) JOYCE D. WILSON AKA Barnes		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 00 Dry Cleaners Park and North Avenues		3. DATE PRONOUNCED DEAD Month Day Year Hour April 15, 1972 7:40 P.M.	
6. SEX Female		7. RACE Negro	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore	
9. DATE OF BIRTH Oct 14, 1945		10. AGE (in years lost birthday) 26	
11. BIRTHPLACE (State or foreign country) Baltimore Md		12. CITIZEN OF WHAT COUNTRY? U.S.A	
13. FATHER'S NAME James Barnes		14. MOTHER'S MAIDEN NAME Lillie Nance	
15. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mechanical Plant		16. KIND OF BUSINESS OR INDUSTRY Cleaning Clothes	
17. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		18. SOCIAL SECURITY NO. 218-44-0913	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) E-9661X DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. Stab wound of chest (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) yes			
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Cleaners	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? Park and North Avenues		22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.) 4-15-72 P.M.	
22E. INJURY OCCURRED WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR? Found stabbed	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Ronald N. Kornblum M.D. EXAMINER'S NAME (Type) Ronald N. Kornblum, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 4/16/72			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE Apr 21, 1972	
24C. NAME OF CEMETERY or CREMATORY Arbutus Men Park		24D. LOCATION (City, town, or county) (State) Arbutus Md	
25A. DATE REC'D BY HEALTH DEPT. APR 17 1972		25B. NAME OF REGISTRAR Ronald N. Kornblum	
25C. FUNERAL DIRECTOR Joseph H. Burns		ADDRESS 2222 W. North Ave	

THE JOURNAL OF THE

THE JOURNAL OF THE

THE JOURNAL OF THE

THE JOURNAL OF THE

THE JOURNAL OF THE

THE JOURNAL OF THE

THE JOURNAL OF THE

THE JOURNAL OF THE

THE JOURNAL OF THE

THE JOURNAL OF THE

THE JOURNAL OF THE

THE JOURNAL OF THE

THE JOURNAL OF THE

THE JOURNAL OF THE

THE JOURNAL OF THE

THE JOURNAL OF THE

THE JOURNAL OF THE

THE JOURNAL OF THE

THE JOURNAL OF THE

THE JOURNAL OF THE

THE JOURNAL OF THE

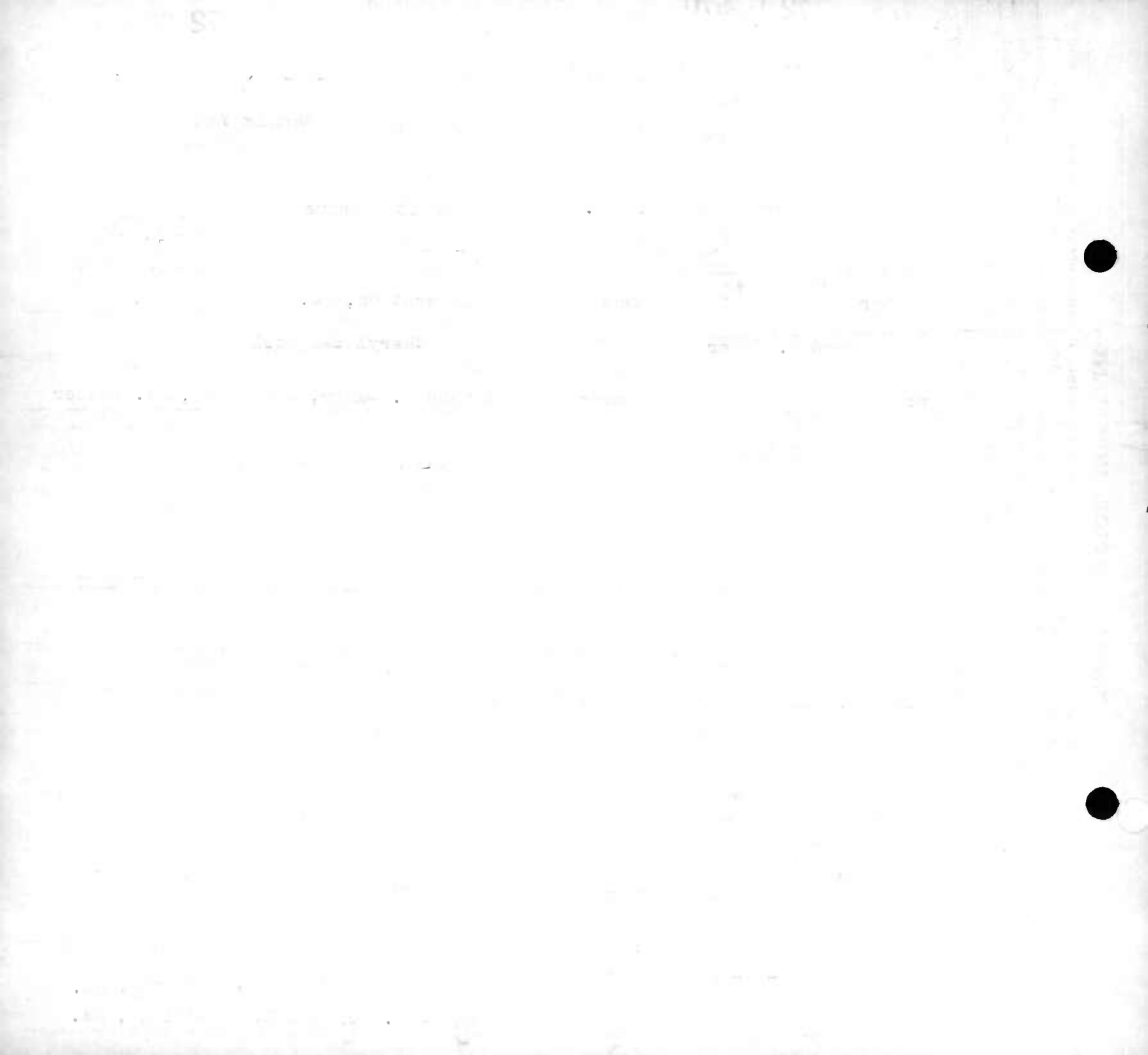
THE JOURNAL OF THE

THE JOURNAL OF THE

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Baltimore City Health Department				REG. NO. <u>72 03870</u>	
<div style="display: flex; justify-content: space-between;"> B-260 72 03870 CERTIFICATE OF DEATH </div>					
1. NAME OF DECEASED (Type or Print) <u>(Shana Baker) Shana Lynn Baker</u>			2. DATE AND HOUR OF DEATH <u>4-11-72</u> <u>11:45 P</u> M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION: <u>37 Mercy Hospital, Inc.</u> IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION:			4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE: <u>Maryland</u> B. COUNTY: <u>Washington</u> C. CITY OR TOWN: <u>Smithburg</u> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER: <u>Christy Avenue</u>		
5. SEX: <u>Female</u>	6. RACE: <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH: <u>3-27-72</u>	9. AGE (In years last birthday):	If Under 1 Yr. Months: <u>16</u> Days: <u>16</u> If Under 24 Hrs. Min.:
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>None</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>None</u>		11. BIRTHPLACE (State or foreign country): <u>Hagerstown, Md.</u>	
12. CITIZEN OF WHAT COUNTRY: <u>USA</u>			13. FATHER'S NAME: <u>Edward P. Baker</u>		
14. MOTHER'S MAIDEN NAME: <u>Cheryl Beightol</u>			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service): <u>no</u>		
16. SOCIAL SECURITY NO.: <u>none</u>		17. INFORMANT: <u>Edward P. Baker, Smithburg, Md. Father</u>			
18. <u>742X I</u> CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Hydrocephalus</u> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C)					
II ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
MEDICAL CERTIFICATION OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION: <u>4-7-72</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED: <u>Hydrocephalus</u>		20A. AUTOPSY? (Yes or No): <u>yes</u>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Notify medical examiner)			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.): (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED: While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (it) (this hospital) attended the deceased from <u>March 27 1972</u> to <u>April 11 1972</u> that (it) (we) last saw the deceased alive on <u>April 11 1972</u> and that (it) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (i) (it) (did) (did not) view the body after death.					
23A. SIGNATURE: <u>David M. Cook</u> DEGREE:			23B. DATE SIGNED: <u>4-12-72</u>		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>
23C. PHYSICIAN'S NAME (Type): <u>DAVID M. COOK, M.D.</u> DEGREE:			23D. ADDRESS: <u>MERCY HOSPITAL</u>		
24A. BURIAL CREMATION, REMOVAL (Specify): <u>Burial</u>	24B. DATE: <u>4-13-72</u>	24C. NAME OF CEMETERY or CREMATORY: <u>Sunset Memorial Park</u>		24D. LOCATION (City, town, or county) (State): <u>Cumberland, Allegany, Md.</u>	
25A. DATE REC'D BY HEALTH DEPT.: <u>APR 18 1972</u>		25B. NAME OF REGISTRAR: <u>James F. Scarpelli</u>		25C. FUNERAL DIRECTOR ADDRESS: <u>Cumberland, Md.</u>	



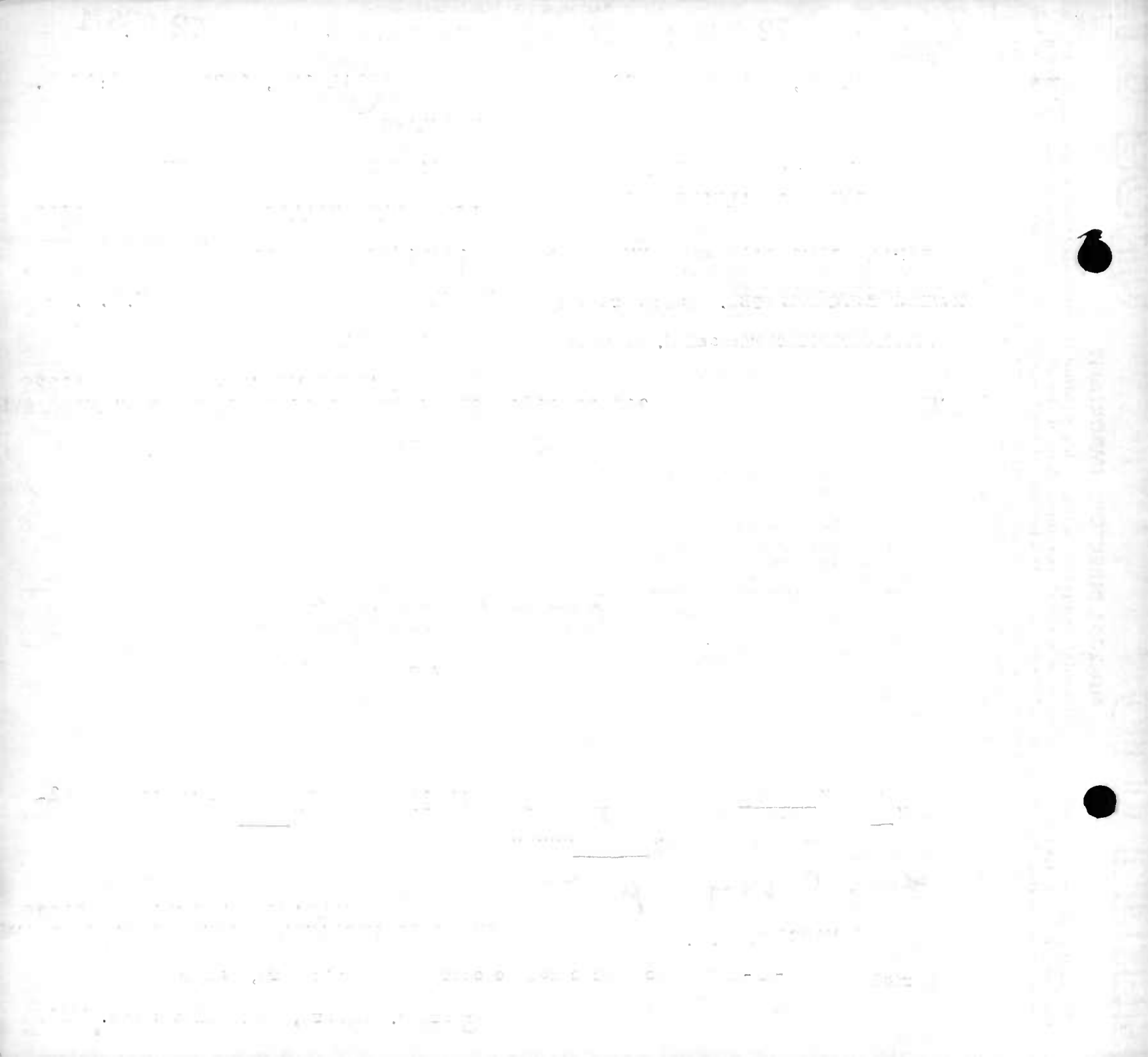
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

CERTIFICATE OF DEATH

REG. NO.

72 03671

BIRTH NO. 1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
GLENN, DELMAR REBECCA		APRIL 12, 1972 6:15 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE B. COUNTY	
ST AGNES HOSPITAL CATON & WILKENS AVE		MARYLAND	
5. SEX		6. RACE	
FEMALE		CAUCASIAN	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH	
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		10/21/00	
9. AGE (In years last birthday)		11. BIRTHPLACE (State or foreign country)	
71		MARYLAND	
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		12. CITIZEN OF WHAT COUNTRY?	
RETIRED TELEPHONE OPER.		U.S.A.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
Michael N. McNamee		ANNIE NEAL	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
NO		219 22 3181	
17. INFORMANT		ADDRESS	
BALTIMORE MARYLAND		21229	
ST AGNES HOSPITAL		CATON & WILKENS AVE	
18. CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH			
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)			
ANTECEDENT CAUSES			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			
II			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
2			
20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
YES			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED	
		White At <input type="checkbox"/> Not White At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I certify that (X) (this hospital) attended the deceased from APRIL 12 19 72 to APRIL 12 19 72 that (X) (we) last saw the deceased alive on APRIL 12 19 72 and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE		23B. DATE SIGNED	
D. Vargas M.D.		4-13-72	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS	
D. VARGAS, M.D.		BALTIMORE MARYLAND 21229	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE	
Burial		4-15-1972	
24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
New Cathedral Cemetery		Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR	
APR 18 1972		Howard H. Hubbard	
25C. FUNERAL DIRECTOR		ADDRESS	
Howard H. Hubbard		4107 Wilkens Ave. 21229	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
CERTIFICATE OF DEATH									
1. NAME OF DECEASED (Type or Print)					2. DATE AND HOUR OF DEATH				
HARRY T. O'NEILL					April 11, 1972				
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD					4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)				
FULL NAME OF HOSPITAL OR INSTITUTION 3450 Caton Avenue Baltimore, Maryland 21229					A. STATE Maryland				
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)					C. CITY OR TOWN Baltimore			D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
					E. STREET AND NUMBER 3450 Caton Avenue				
5. SEX Male	6. RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12-9-1889	9. AGE (In years lost birthday) 82	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Shipping Clerk				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) New York		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Bartholomew O'Neill					14. MOTHER'S MAIDEN NAME Bridget (Unknown)				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. 212-10-6828		17. INFORMANT Mrs. Theresa C. O'Neill, 3450 Caton Ave.			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc., it means the disease, injury or complication which caused death.) <i>Anteroselective Cardiovascular Disease</i>				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Myocardial infarction</i>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) DUE TO, OR AS A CONSEQUENCE OF: <i>Myocardial infarction</i>					
(C) DUE TO, OR AS A CONSEQUENCE OF: <i>Myocardial infarction</i>									
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).									
19A. DATE OF OPERATION Mar 20, 1972			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Chest			20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			21B. PLACE OF INJURY (e.g., home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR? <i>Heart disease</i>			
22. I certify that (I) (this hospital) attended the deceased from <i>Mar 20</i> 19 <i>72</i> to <i>April 4</i> 19 <i>72</i> , that (I) (we) last saw the deceased alive on <i>19</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <i>Charles Cahn</i>					23B. DATE SIGNED 4/13/72			23C. PHYSICIAN'S NAME (Type) Charles Cahn	
23D. ADDRESS 2145 W. Baltimore Street, Baltimore, Md.									
24A. BURIAL CREMATION, REMOVAL (Specify) Burial			24B. DATE 4-14-1972		24C. NAME OF CEMETERY OR CREMATORY Holy Redeemer Cemetery			24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. APR 18 1972			25B. NAME OF REGISTRAR <i>Howard H. Hubbard</i>			25C. FUNERAL DIRECTOR Howard H. Hubbard, 4107 Wilkens Ave. 21229			

100

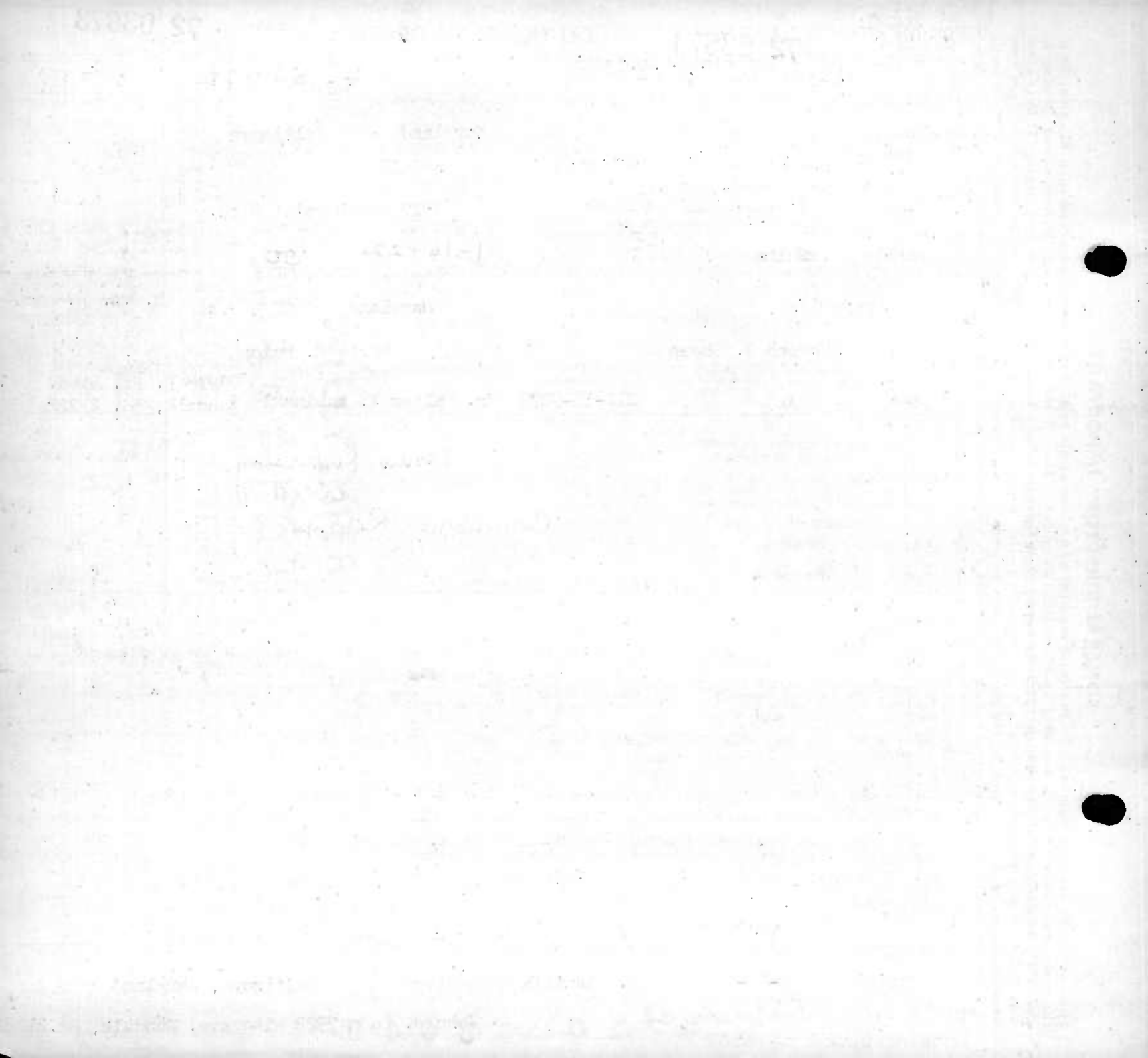
— 3 —

1

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 03673	
BIRTH NO. 1. NAME OF DECEASED (Type or Print) Elizabeth M. Lubinski Lubinski Elizabeth		2. DATE AND HOUR OF DEATH 4-10-1972 9:45 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION South Baltimore Gen. Hospital 3001 - S. Hanover St., Baltimore, Maryland 21230.			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN Dundalk D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER 3917 North Point Blvd.		
5. SEX Female	6. RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-16-22	9. AGE (In years lost birthday) 50	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.			13. FATHER'S NAME Joseph F. Shepp		
14. MOTHER'S MAIDEN NAME Marie M. Mulcahy			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		
16. SOCIAL SECURITY NO. 212-18-9278			17. INFORMANT Husband: Mr. Walter A. Lubinski ADDRESS 3917 N. Pt. Blvd. Dundalk, Md. 21222		
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH Cardio-Respiratory Arrest ANTECEDENT CAUSES Carcinoma Rectum DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 3-20-1972 to 4-10-1972 , that (I) (we) last saw the deceased alive on 4-10-1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Ahmed M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>				23B. DATE SIGNED 4-10-72	
23C. PHYSICIAN'S NAME (Type) Dr. Ahmad M.D.				23D. ADDRESS 3001 - S. Hanover St. Baltimore, Md 21230.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4-14-72		24C. NAME OF CEMETERY or CREMATORY St. Stanislaus Cemetery	
24D. LOCATION (City, town, or county) (State) Baltimore, Maryland		25A. DATE REC'D BY HEALTH DEPT. APR 18 1972 25B. NAME OF REGISTRAR Sub E. J. ... 25C. FUNERAL DIRECTOR John J. Duda ADDRESS 7922 Wise Ave. Dundalk, Md. 21222			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 03674	
BIRTH NO. 8-145 72 03674				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <u>Rubeling Audrey H. Rubeling</u>			2. DATE AND HOUR OF DEATH <u>4-11-72 - 1:00 AM</u>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>North Charles Gen. Hosp. Baltimore, Md.</u>			A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore</u>		
			C. CITY OR TOWN <u>Dundalk</u>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
			E. STREET AND NUMBER <u>8127 Del Haven Road</u>		
5. SEX <u>Female</u>	6. RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-20-1952</u>		9. AGE (In years last birthday) <u>52</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			13. FATHER'S NAME <u>Wilton Sparks</u>		
14. MOTHER'S MAIDEN NAME <u>Nettie Jester</u>			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		
16. SOCIAL SECURITY NO. <u>217-12-4438</u>			17. INFORMANT <u>Daughter: Mrs. Deve Kordek</u> ADDRESS <u>8127 Del Haven Road Dundalk, Md. 21222</u>		
18. <u>153.3 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH			CAUSE OF DEATH		
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)			(A) IMMEDIATE CAUSE <u>CA, Sigmoid Colon</u> DUE TO, OR AS A CONSEQUENCE OF: <u>4 days</u>		
ANTECEDENT CAUSES			(B) <u>(Septic Shock)-Septicemia</u> DUE TO, OR AS A CONSEQUENCE OF:		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(C) _____		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>1</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>CA, Sigmoid colon</u>		20A. AUTOPSY? (Yes or No) <u>No</u>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>4-2-1972</u> to <u>4-11-1972</u> that (I) (we) last saw the deceased alive on <u>4-11-1972</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Narciso A. de Bora</u>				23B. DATE SIGNED <u>4-11-72</u>	
23C. PHYSICIAN'S NAME (Type) <u>Narciso A. de Bora, Md</u>				23D. ADDRESS <u>North Charles Gen Hosp Baltimore, Md</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>4-14-72</u>		24C. NAME of CEMETERY or CREMATORY <u>Gardens of Faith Cemetery</u>	
24D. LOCATION (City, town, or county) <u>Baltimore, Maryland</u>		24E. DATE REC'D BY HEALTH DEPT. <u>APR 18 1972</u>			
24F. NAME OF REGISTRAR <u>John J. Duda</u>		24G. FUNERAL DIRECTOR ADDRESS <u>7922 Wise Ave. Dundalk, Md. 21222</u>			

4/7/72 date of operation.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>72 03675</u>	
M-620 72 03675		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
MEYERS, IDA K		APRIL 11, 1972		9:45A M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION ST. AGNES HOSPITAL 40		A. STATE		B. COUNTY	
		MARYLAND			
		C. CITY OR TOWN		D. INSIDE CITY LIMITS?	
BALTIMORE		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
E. STREET AND NUMBER					
312 MARTINGALE AVE		21229			
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years lost birthday)	10. Under 1 Yr. Months Days
FEMALE	CAUCASIAN	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	06/06/91	80	If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
HOMEMAKER				MARYLAND	
12. FATHER'S NAME		13. MOTHER'S MAIDEN NAME			
CHARLES FRITZ		CARRIE KRIETLE FRITZ KRIETE			
14. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		15. SOCIAL SECURITY NO.		16. INFORMANT	
NONE		214-50-3717		Mr. Robert H. Chandler, 312 Martingale Ave. ST. AGNES HOSPITAL RECORDS	
17. CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
<p>18. <u>440.9 I</u></p> <p>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</p> <p>(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)</p> <p>ANTECEDENT CAUSES</p> <p>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p>		(A) IMMEDIATE CAUSE		Heart Failure	
		(B) Generalized arteriosclerosis			
		(C)			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
NONE		NONE			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?			
	While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				
22. I certify that (I) (this hospital) attended the deceased from <u>APRIL 2</u> 19 <u>72</u> to <u>APRIL 11</u> 19 <u>72</u> that (I) (we) lost saw the deceased alive on <u>APRIL 11</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE		23B. DATE SIGNED			
<u>J. S. Lee</u>		4/11/72			
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
J. S. LEE		BALTIMORE, MARYLAND 21229 ST. AGNES HOSPITAL; CATON & WILKENS AVES			
24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county)	(State)	
Burial	4-14-1972	Mt. Olivet Cemetery	Baltimore, Maryland		
25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR		ADDRESS	
APR 18 1972	Howard H. Hubbard	Funeral Home,		4107 Wilkens Avenue	

11 11 11

11 11 11

11 11 11

11 11 11

11 11 11

11 11 11

11 11 11

11 11 11

11 11 11

11 11 11

11 11 11

11 11 11

11 11 11

11 11 11

11 11 11

11 11 11

11 11 11

11 11 11

11 11 11

11 11 11

11 11 11

11 11 11

11 11 11

11 11 11

11 11 11

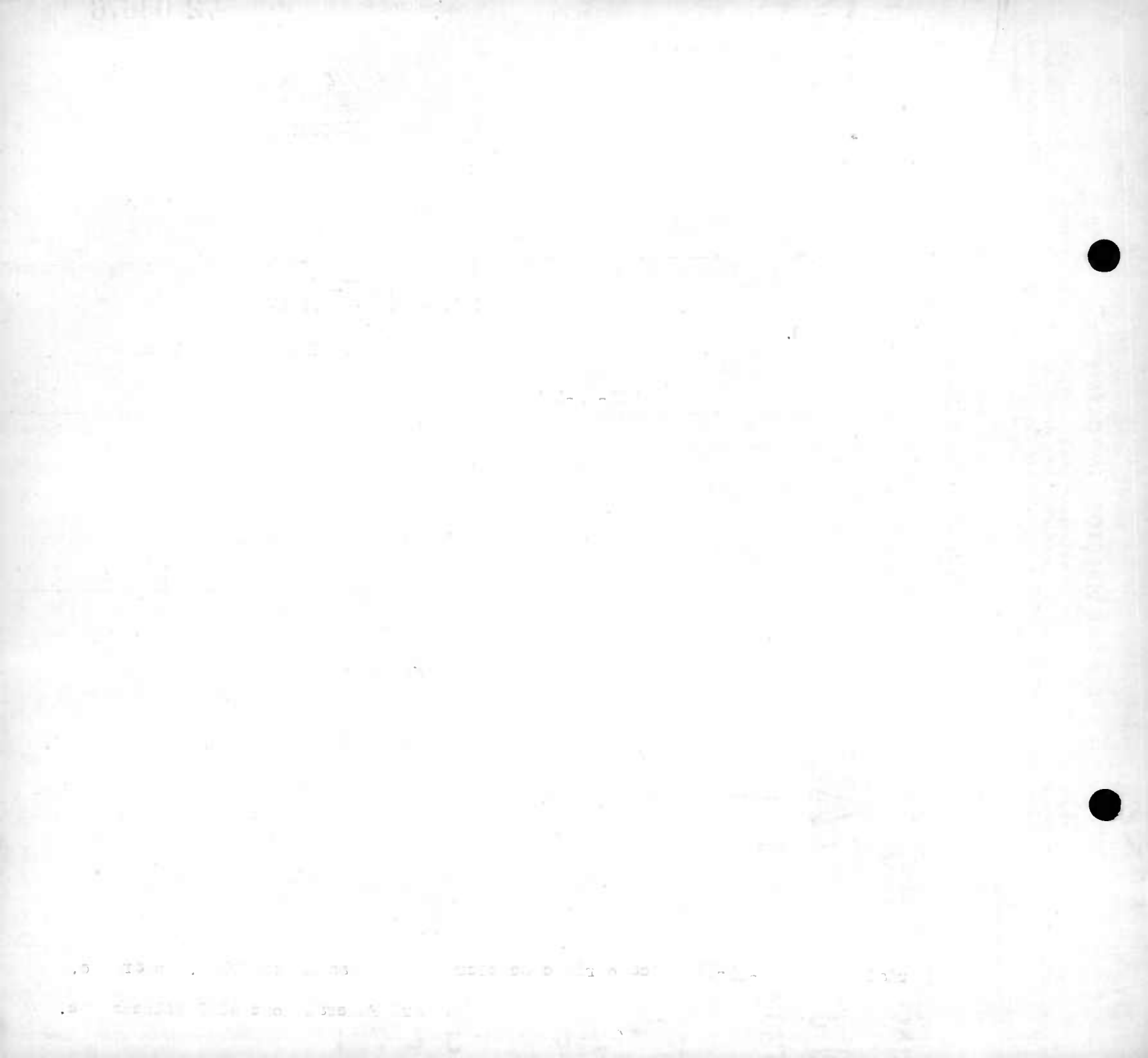
11 11 11

11 11 11

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT										
72 03676										
72 03676										
REG. NO.										
S-536		72 03676		72 03676			72 03676			
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			
		SNYDER, CHARLES GARFIELD			4/10/72			6 30 P M.		
FULL NAME OF HOSPITAL OR INSTITUTION		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			5. CITY OR TOWN		
UNIVERSITY OF MARYLAND HOSP		38			MD. XXXXX 2101			BALTIMORE		
					E. STREET AND NUMBER			D. INSIDE CITY LIMITS?		
					405 W PRATT STREET			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?	13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME	
M	W	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	5-31-10	61	RETIRED - BREWERY WORKER	MARYLAND	U.S.A.	CHARLES SNYDER	ROSA XXXXXXXX Nagel	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		18. ADDRESS		19. ADDRESS		
NO		212-05-2620		ROBERT SNYDER		2400 BROWN AVE		BALTO. MD 21230		
1B. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
410.9 + 250.9		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: MYOCARDIAL INFARCT				IMMEDIATE				
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		(B) ASCVD				YEARS				
ANTECEDENT CAUSES		(C)								
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.										
II										
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		DIABETES MELLITUS								
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
0				NO						
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)						
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?						
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>								
22. I certify that (I) (the hospital) attended the deceased from 4/10 19 72 to 4/10 19 72, that (I) (we) last saw the deceased alive on N/A 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.										
23A. SIGNATURE		23B. DATE SIGNED		23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS		23E. ADDRESS		
James E. M... M.D.		4/10/72								
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county)		24E. LOCATION (State)		
Burial		4-13-72		Meadowridge Cemetery		Washington Blvd. Howard Co.				
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		25D. ADDRESS		25E. ADDRESS		
APR 18 1972		R... J...		Hubbard Funeral Home		4107 Wilkens Ave.				



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 8-100				BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 03677	
1. NAME OF DECEASED (Type or Print) ANNA SEIPP				2. DATE AND HOUR OF DEATH 4/13/72 5:30 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD Baltimore City Hospital 21224				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD B. COUNTY 2741			
FULL NAME (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 4940 Eastern Avenue Baltimore, Maryland				C. CITY OR TOWN BALTO.		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER 4120 ST Thomas Ave 21206							
5. SEX Female	6. RACE Caucasian	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-7-14	9. AGE (In years last birthday) 58	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10B. KIND OF BUSINESS OR INDUSTRY —		11. BIRTHPLACE (State or foreign country) USA		
13. FATHER'S NAME — Frank Rezek			14. MOTHER'S MAIDEN NAME Sophia Jirsa				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO. 215-08-0915		17. INFORMANT 4940 Eastern Avenue Baltimore, Maryland 21224		
18. 436101 + 571.0 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) Cerebral vascular accid.				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4/10/72			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Hypertension				(B) altered mental status			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). baennec's cirrhosis							
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) No		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 4/1/72 19 to 4/13/72 19 that (I) (we) last saw the deceased alive on 4/13/72 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
23A. SIGNATURE Peter J. Dorson M.D.				23B. DATE SIGNED 4/13/72		23C. PHYSICIAN'S NAME (Type) PETER J. DORSON M.D.	
23D. ADDRESS 6152 EAST PRATT ST 21224							
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4-17-72		24C. NAME OF CEMETERY OR CREMATORY Holy Cross Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. APR 18 1972		25B. NAME OF REGISTRAR John C. Miller Inc-6415 Belair Rd. -21206		25C. FUNERAL DIRECTOR John C. Miller Inc-6415 Belair Rd. -21206			

15 Dec 73

MD

1310 TO

4130 ST Thomas Ave

22

2-1-14

X

Epstein

Epstein's

Epstein's

NO

4/1/73

4/1/73

Robert J. Brown MD

1212 2 DAWSON

1212 2 DAWSON

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Baltimore City Health Department				REG. NO.	
C-515		72 03678		72 03678	
CERTIFICATE OF DEATH					
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		EAM PANELLA, FERDINANDO		4/11/72 9:40 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION 44 UNION MEMORIAL HOSPITAL			A. STATE & COUNTY MARYLAND 2734		
(If not in hospital or institution, give street address or location)			C. CITY OR TOWN BALTIMORE		
			D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
			E. STREET AND NUMBER 5432 BELAIR ROAD		
5. SEX MALE	6. RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11/5/94	9. AGE (In years lost birthday) 78	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) ITALY	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME UNKNOWN		14. MOTHER'S MAIDEN NAME UNKNOWN	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 765-20-2515		17. INFORMANT Bruna Campanella (wife)	
18. 285.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH CARDIAC ARREST		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: CONGESTIVE HEART FAILURE			
		(B) DUE TO, OR AS A CONSEQUENCE OF: ANEMIA			
		(C) UREMIA			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes, or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 4/10/72 19 to 4/11/72 19, that (I) (we) last saw the deceased alive on 4/11/72 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE A. del Busto				23B. DATE SIGNED 4/11/72	
23C. PHYSICIAN'S NAME (Type) A. del Busto, MD				23D. ADDRESS Union Memorial Hospital	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4/15/72		24C. NAME OF CEMETERY or CREMATORY Gardens of Faith Cemetery	
24D. LOCATION Balto. Md.		24E. DATE REC'D BY HEALTH DEPT. APR 18 1972		24F. NAME OF REGISTRAR Schimunek Funeral Homes, Inc.	
24G. ADDRESS 3331 Brehms Lane, Balto. Md. 21213		24H. DATE OF DEATH 4/11/72		24I. TIME OF DEATH 9:40 P.M.	

2002 10/24

11/2/04

USA

ITALY

UNKNOWN

PAVE WHITE

RECEIVED

UNKNOWN

CLINICAL REPORT

CLINICAL REPORT

REPORT

REPORT

11/2/04

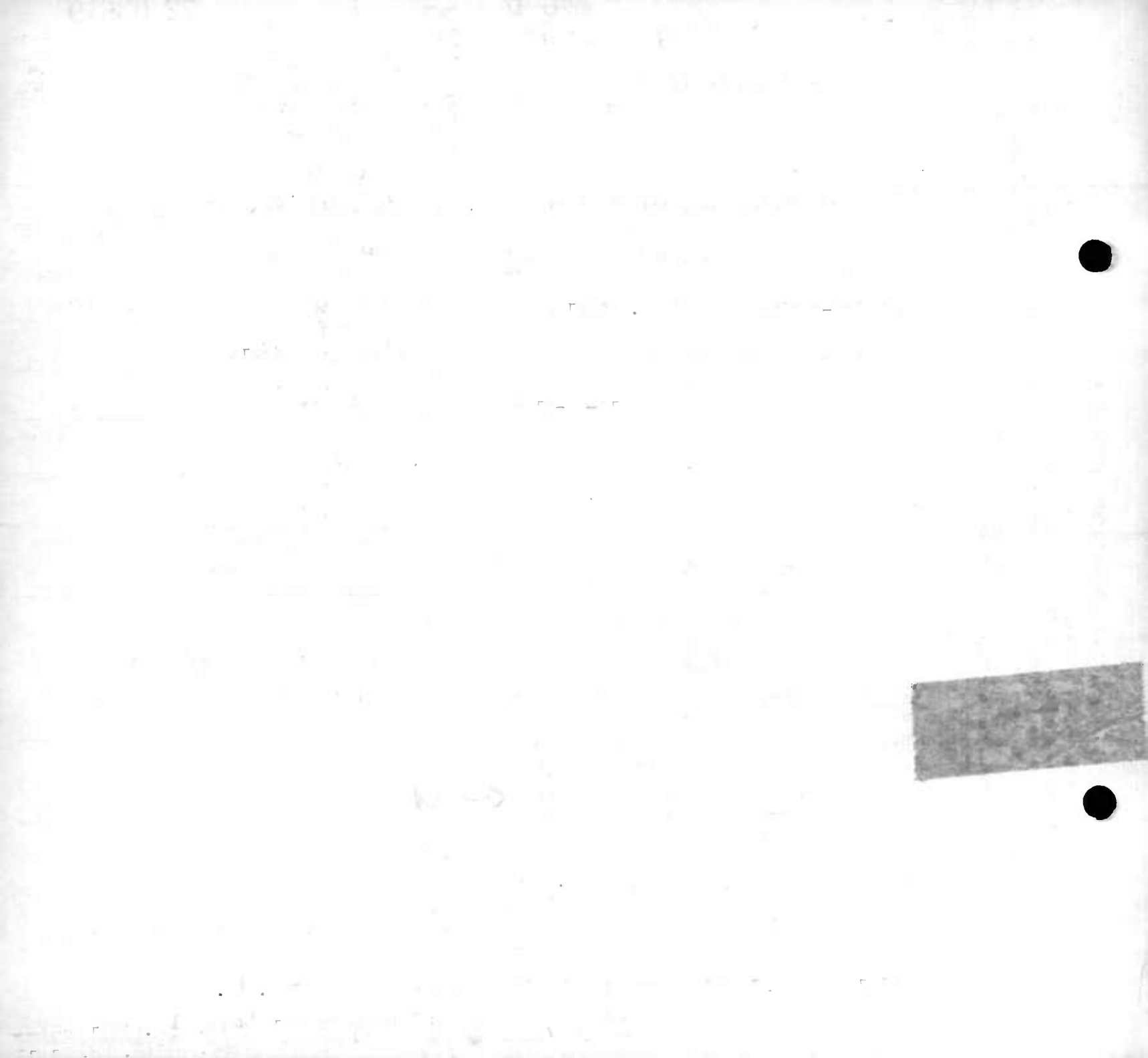
11/2/04

11/2/04

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

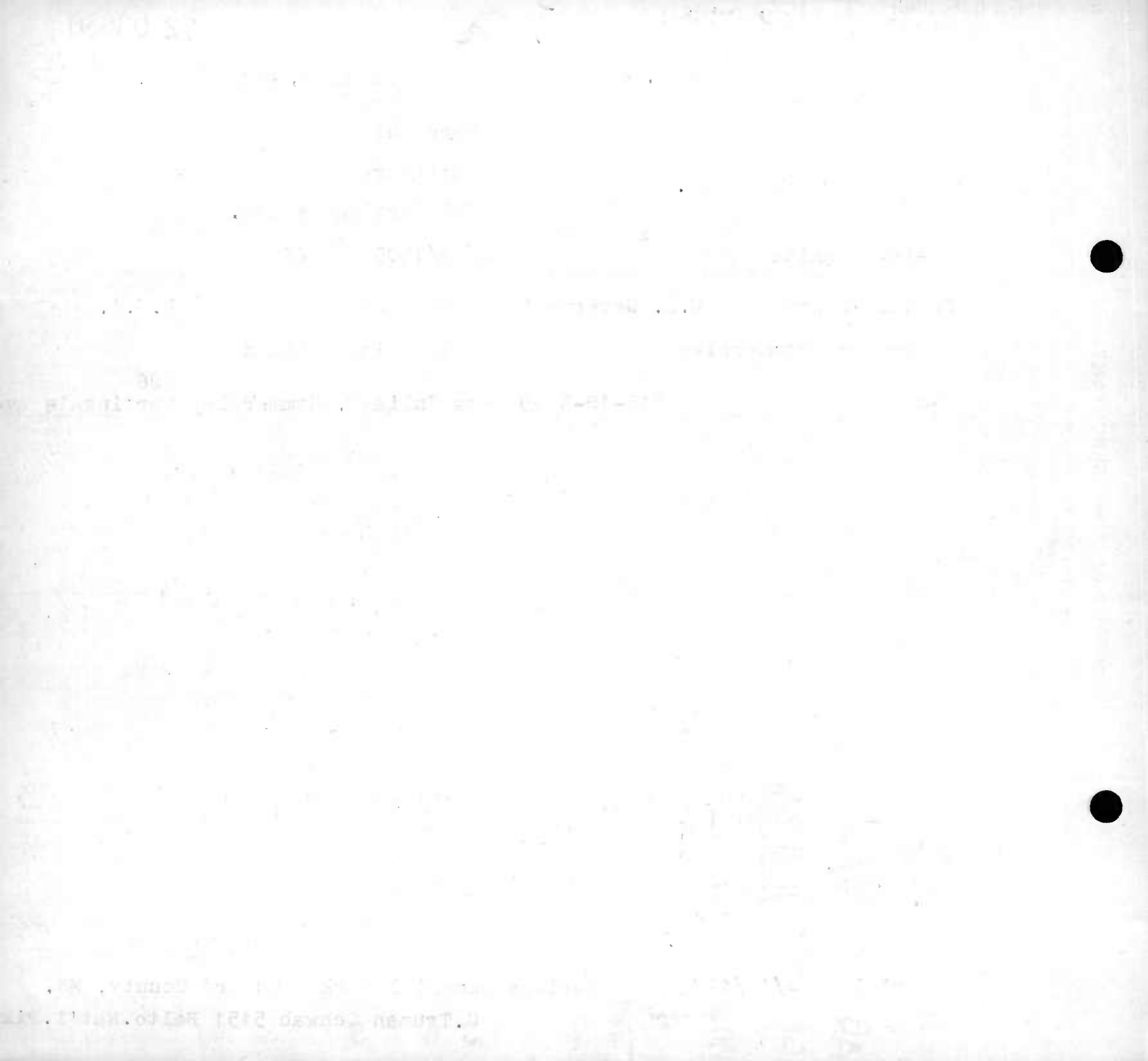
BALTIMORE CITY HEALTH DEPARTMENT				72 03679	
B-550 72 03679				CERTIFICATE OF DEATH	
BIRTH NO.				REG. NO.	
1. NAME OF DECEASED (Type or Print) Baumann William			2. DATE AND HOUR OF DEATH April 11 72 1 45 p.m.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD B. COUNTY Balto		
FULL NAME OF HOSPITAL OR INSTITUTION 44 UNION MEMORIAL HOSPITAL			C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			E. STREET AND NUMBER 2751 PETHAM Ave Balto Md 21213		
5. SEX M	6. RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 01-01-04	9. AGE (In years last birthday) 68	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) machinist-retired		10B. KIND OF BUSINESS OR INDUSTRY Beth. Steel		11. BIRTHPLACE (State or foreign country) Germany	
12. CITIZEN OF WHAT COUNTRY? American		13. FATHER'S NAME Paul Baumann		14. MOTHER'S MAIDEN NAME Marie Eisele	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 213-09-3195		17. INFORMANT CHART	
18. 45-0X1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Pulmonary embolism			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Pulmonary embolism		
(B) DUE TO, OR AS A CONSEQUENCE OF:			(C) DUE TO, OR AS A CONSEQUENCE OF:		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 04-01-1972 to 04-11-1972 that (I) (we) last saw the deceased alive on 04-11-1972 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Julio Bertorini				23B. DATE SIGNED 04-11-72	
23C. PHYSICIAN'S NAME (Type) JULIO BERTORINI				23D. ADDRESS UNION MEMORIAL HOSPITAL	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4/15/72		24C. NAME of CEMETERY or CREMATORY Gardens of Faith Cemetery	
24D. LOCATION Balto, Md.		24E. NAME of REGISTRAR Schimunek		24F. FUNERAL DIRECTOR Schimunek Funeral Homes, Inc. 3331 Brehms Lane, Balto. Md. 21213	
25A. DATE REC'D BY HEALTH DEPT. APR 18 1972		25B. NAME OF REGISTRAR Schimunek		25C. FUNERAL DIRECTOR Schimunek	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

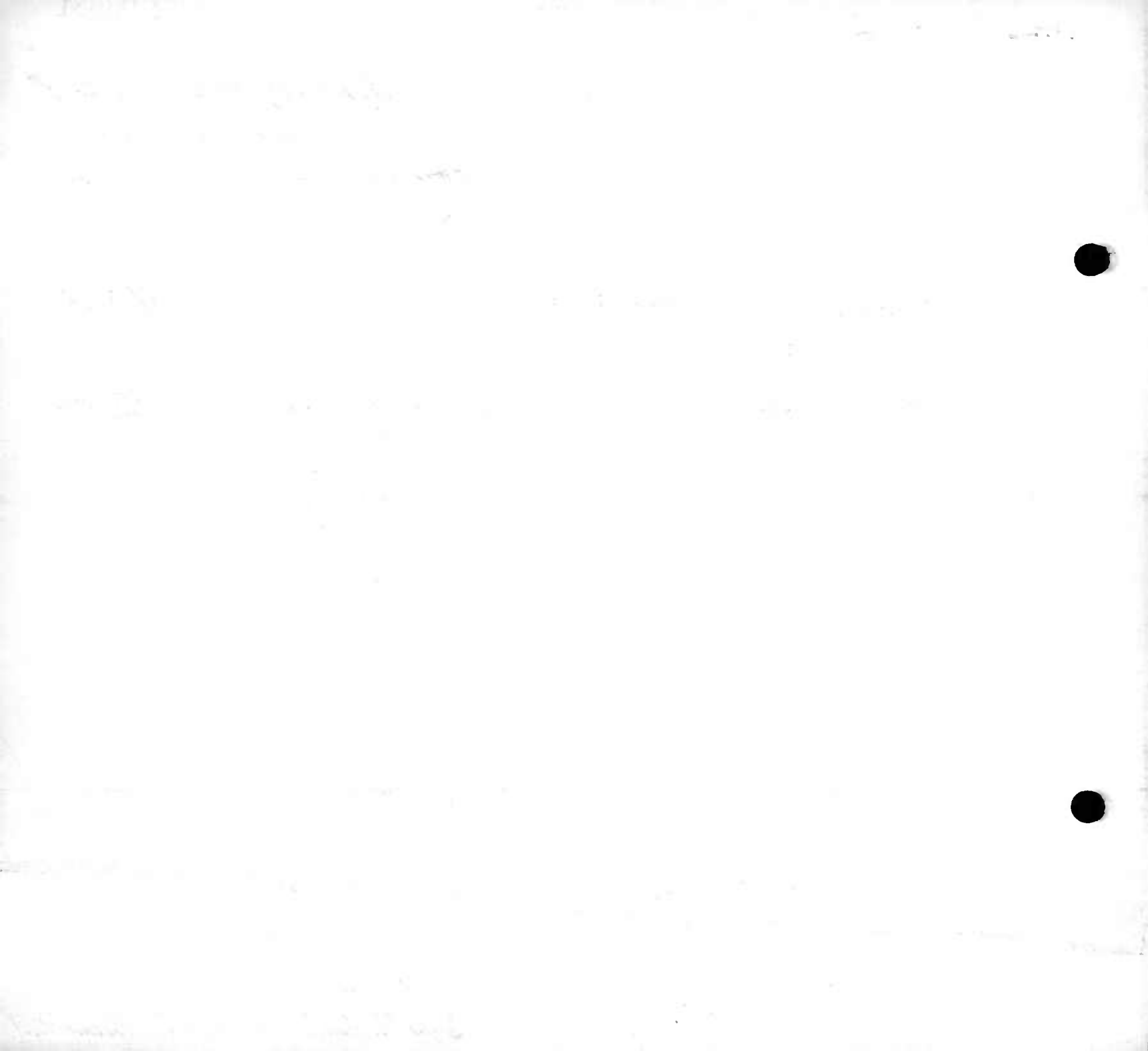
BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. <u>72 03680</u>	
BIRTH NO. <u>4-562</u> <u>72 03680</u>		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) Charles W. Hammersley		2. DATE AND HOUR OF DEATH April 14, 1972 <u>230</u> P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>00</u> 326 Martingale Ave.		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY <u>2541</u> C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 326 Martingale Ave.	
5. SEX Male	6. RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/22/1905 9. AGE (In years lost birthday) 66 If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Postal worker		10B. KIND OF BUSINESS OR INDUSTRY U.S. Government	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George Hammersley		14. MOTHER'S MAIDEN NAME Katherine Hibline	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 215-10-3499	
17. INFORMANT Mrs Julia E. Hammersley		ADDRESS 326 Martingale Ave.	
18. <u>410.9</u> I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE Acute coronary occlusion, i.e. that DUE TO, OR AS A CONSEQUENCE OF: (B) Arteriosclerotic C.V. dis 3 years DUE TO, OR AS A CONSEQUENCE OF: (C) Aortic aneurysm Myocardial infarction; periph. vasc. dis 5 years	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
19A. DATE OF OPERATION <u>0</u>	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)	21E. INJURY OCCURRED While At <input type="checkbox"/> Not While <input type="checkbox"/> Work At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>4/8</u> <u>Jan.</u> 19 <u>62</u> to <u>4/14</u> 19 <u>72</u> and that in (my) <u>own</u> opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <u>Christian B. Mass</u>		23B. DATE SIGNED <u>4/15/72</u>	
23C. PHYSICIAN'S NAME (Type or Print) CHRISTIAN B. MASS, M.D.		23D. ADDRESS Howard County Medical Center 2043	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 4/17/1972	24C. NAME OF CEMETERY OR CREMATORY Meadowridge Memorial Park	24D. LOCATION (City, town, or county) (State) Howard County, Md.
25A. DATE REC'D BY HEALTH DEPT. APR 18 1972	25B. NAME OF REGISTRAR G. E. Schwab	25C. FUNERAL DIRECTOR ADDRESS G. Truman Schwab 5151 Balto. Nat'l. Park	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

K-652 72 Q3681		BALTIMORE CITY HEALTH DEPARTMENT		72 Q3681	
BIRTH NO.		CERTIFICATE OF DEATH		REG. NO.	
1. NAME OF DECEASED (Type or Print)			2. DATE AND HOUR OF DEATH		
KERNs, SARA E.			April 13, 1972 8:20 P.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			A. STATE B. COUNTY		
South Baltimore General Hospital 43			Md. Anne Arundel 5200		
5. SEX F. 6. RACE W. 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			C. CITY OR TOWN D. INSIDE CITY LIMITS?		
			Cotter Burien YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			E. STREET AND NUMBER		
Housewife			409, Magnolia Rd. P. 21		
10B. KIND OF BUSINESS OR INDUSTRY			9. AGE (In years last birthday)		
Own Home			10-22-89 82		
11. BIRTHPLACE (State or foreign country)			12. CITIZEN OF WHAT COUNTRY?		
Va.			U.S.A.		
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
Boykin Knight			Sophronia Musgrave		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		
No			302-12-777A		
17. INFORMANT			ADDRESS		
Mr. Harley E. Kerns			Same as #4		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
204.1 I					
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		
ANTECEDENT CAUSES			Chronic lymphocytic leukemia		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(B) DUE TO, OR AS A CONSEQUENCE OF:		
			Anemia		
			(C) DUE TO, OR AS A CONSEQUENCE OF:		
			Bone marrow depression		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
2				✓	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from 4-13-72 11:50 AM to 4-13-72 8:20 PM 19 that (I) (we) last saw the deceased alive on 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
P. Lawhney				4-13-72	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
DR. LOVICE				So. Balt. Gen'l Hosp.	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY	
Cremation		4/17/72		London Park Cemetery	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
APR 18 1972		Robert E. Taylor		N. E. Quinn	
				ADDRESS	
				5300 E. Federal Ave, Cotter Burien Md.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. _____	
14-625 72 03682		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <u>HARRISON CLARENCE M.</u>		2. DATE AND HOUR OF DEATH <u>4-16-72</u> <u>9.30</u> P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>UNION MEMORIAL HOSPITAL</u>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MD</u> B. COUNTY <u>BA</u> C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>4121 St. Thomas Avenue</u>			
5. SEX <u>M</u>	6. RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-26-94</u>	9. AGE (In years last birthday) <u>77</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Steelworker</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Sparrows Point</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	12. CITIZEN OF WHAT COUNTRY? <u>AMERICAN</u>
13. FATHER'S NAME <u>WILLIAM HARRISON (D)</u>		14. MOTHER'S MAIDEN NAME <u>Agnes [REDACTED] (D)</u>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) <u>No</u>	
16. SOCIAL SECURITY NO. <u>217-09-7929</u>		17. INFORMANT <u>CHART</u>		ADDRESS	
18. <u>162.1</u> I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Ca of lung</u> (B) DUE TO, OR AS A CONSEQUENCE OF: (C)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>NO</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>04-03-1972</u> to <u>04-16-1972</u> , that (I) (we) last saw the deceased alive on <u>04-16-1972</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>[Signature]</u>		23B. DATE SIGNED <u>04-18-72</u>		23C. PHYSICIAN'S NAME (Type) <u>JULIO BEATO RINI</u>	
23D. ADDRESS <u>UNION MEMORIAL HOSPITAL</u>		24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>			
24B. DATE <u>4/19/72</u>		24C. NAME OF CEMETERY or CREMATORY <u>Gardens of Faith Cem.</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore Maryland</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>APR 18 1972</u>		25B. NAME OF REGISTRAR <u>Robert E. Fisher</u>		25C. FUNERAL DIRECTOR <u>Leonard J. Ruck Inc.</u>	
				ADDRESS <u>5305 Harford Rd.</u>	

UNITED STATES DEPARTMENT OF AGRICULTURE

WASHINGTON, D. C. 20250

Special Agent in Charge

XXXXXX

ST-100-1000

Reliance Insurance

Division of Insurance

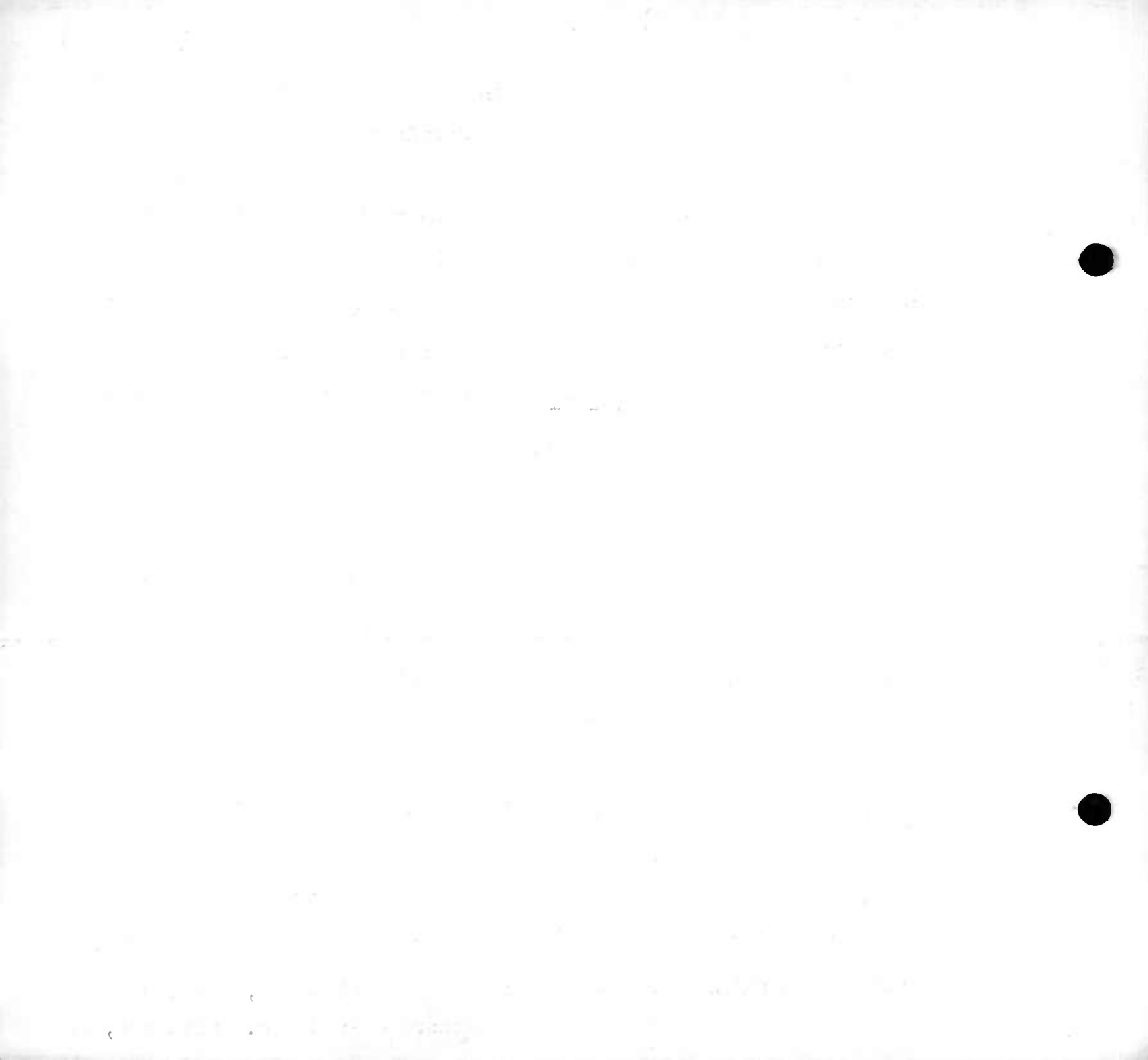
Special

Insurance Company of North America

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>72 03683</u>	
C-232 72 03683				CERTIFICATE OF DEATH	
BIRTH NO. <u>C-232</u>		1. NAME OF DECEASED (Type or Print) <u>Rosalia C. Castiglia</u>		2. DATE AND HOUR OF DEATH <u>4/15/72</u> <u>545</u> A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>48 Md. General Hosp</u>			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>2758</u> C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>2044 E. Belvedere Ave</u>		
5. SEX <u>F</u>	6. RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7/26/97</u>	9. AGE (In years last birthday) <u>74</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			13. FATHER'S NAME <u>Frank Zito</u>		
14. MOTHER'S MAIDEN NAME <u>Concetta ?</u>			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No.</u>		
16. SOCIAL SECURITY NO. <u>212-07-2812B</u>			17. INFORMANT <u>Mrs Antoinette Simms</u> <u>Admission Sheet</u>		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>437.9 I</u> CAUSE OF DEATH <u>Possible Cerebrovascular Accident, Acute</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>30 min</u>			19. IMMEDIATE CAUSE <u>Possible Aspiration</u>		
20. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>II</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <u>Valvulus of Sigmoid Colon</u>			21. DUE TO, OR AS A CONSEQUENCE OF: <u>Cerebrovascular Arteriosclerotic Disease with multiple old strokes</u> <u>10 yrs</u>		
22. DUE TO, OR AS A CONSEQUENCE OF: <u>Arteriosclerotic Cardiovascular Disease</u> <u>10 yrs</u>			23. DUE TO, OR AS A CONSEQUENCE OF: <u>Valvulus of Sigmoid Colon</u>		
19A. DATE OF OPERATION <u>4/7/72</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Valvulus of Sigmoid Colon</u>		20A. AUTOPSY? (Yes or No) <u>No</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>4/7/72</u> 19 <u>72</u> to <u>4/9/72</u> 19 <u>72</u> that (I) (we) last saw the deceased alive on <u>4/9/72</u> and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Willard P. Amoss M.D.</u>				23B. DATE SIGNED <u>4/15/72</u>	
23C. PHYSICIAN'S NAME (Type) <u>Willard P. Amoss M.D.</u>				23D. ADDRESS <u>Md. General Hosp. Balto Md</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>4/18/72</u>		24C. NAME of CEMETERY or CREMATORY <u>Holy Redeemer</u>	
24D. LOCATION (City, town, or county) <u>Baltimore, Maryland</u>		24E. STATE (State) <u>Md.</u>			
25A. DATE REC'D BY HEALTH DEPT. <u>APR 18 1972</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor, M.D.</u>		25C. FUNERAL DIRECTOR <u>Leonard J. Huck Inc.</u>	
25D. ADDRESS <u>Baltimore, Md</u>					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>72 03684</u>
BIRTH NO. 1. NAME OF DECEASED (Type or Print) <u>MARY Emma AMADIO</u>		2. DATE AND HOUR OF DEATH <u>APRIL - 16 - 1972 2:15 P. M.</u>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <u>HOME</u> (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>3618 BELLEVALE AVE</u> <u>BALTIMORE 21206</u>		4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>2745</u> C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>3618 Bellevale Ave</u>		
5. SEX <u>Female</u>	6. RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 26, 1904</u>	9. AGE (In years last birthday) <u>67</u> If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Seamstress</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Italy</u>		
11. BIRTHPLACE (State or foreign country) <u>Italy</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>Anthony DiFilippo</u>		14. MOTHER'S MAIDEN NAME <u>Rose Lianca Prima</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>214-14-2372</u>		17. INFORMANT <u>Mr John Root</u>
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH <u>ADENOCARCINOMA OF RECTUM</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>WITH WIDE SPREAD METASTASES</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from <u>MAY</u> 19 <u>71</u> to <u>APRIL</u> 19 <u>72</u> that (I) (we) last saw the deceased alive on <u>MARCH</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.				
23A. SIGNATURE <u>Joseph Notarangelo M.D.</u>			23B. DATE SIGNED <u>APRIL - 17 - 1972</u>	
23C. PHYSICIAN'S NAME (Type) <u>JOSEPH NOTARANGELO M.D.</u>			23D. ADDRESS <u>301 ST. PAUL PLACE BALTO 21202</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>4/19/72</u>		24C. NAME OF CEMETERY or CREMATORY <u>Holy Redeemer</u>
24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>		25A. DATE REC'D BY HEALTH DEPT. <u>APR 18 1972</u>		
25B. NAME OF REGISTRAR <u>Robert E. J. J. J. J.</u>		25C. FUNERAL DIRECTOR <u>Leonard J. Ruck Inc. Baltimore, Md</u>		

1475 82

1975

1975

1975

1975

1975

1975

1975

1975

1975

1975

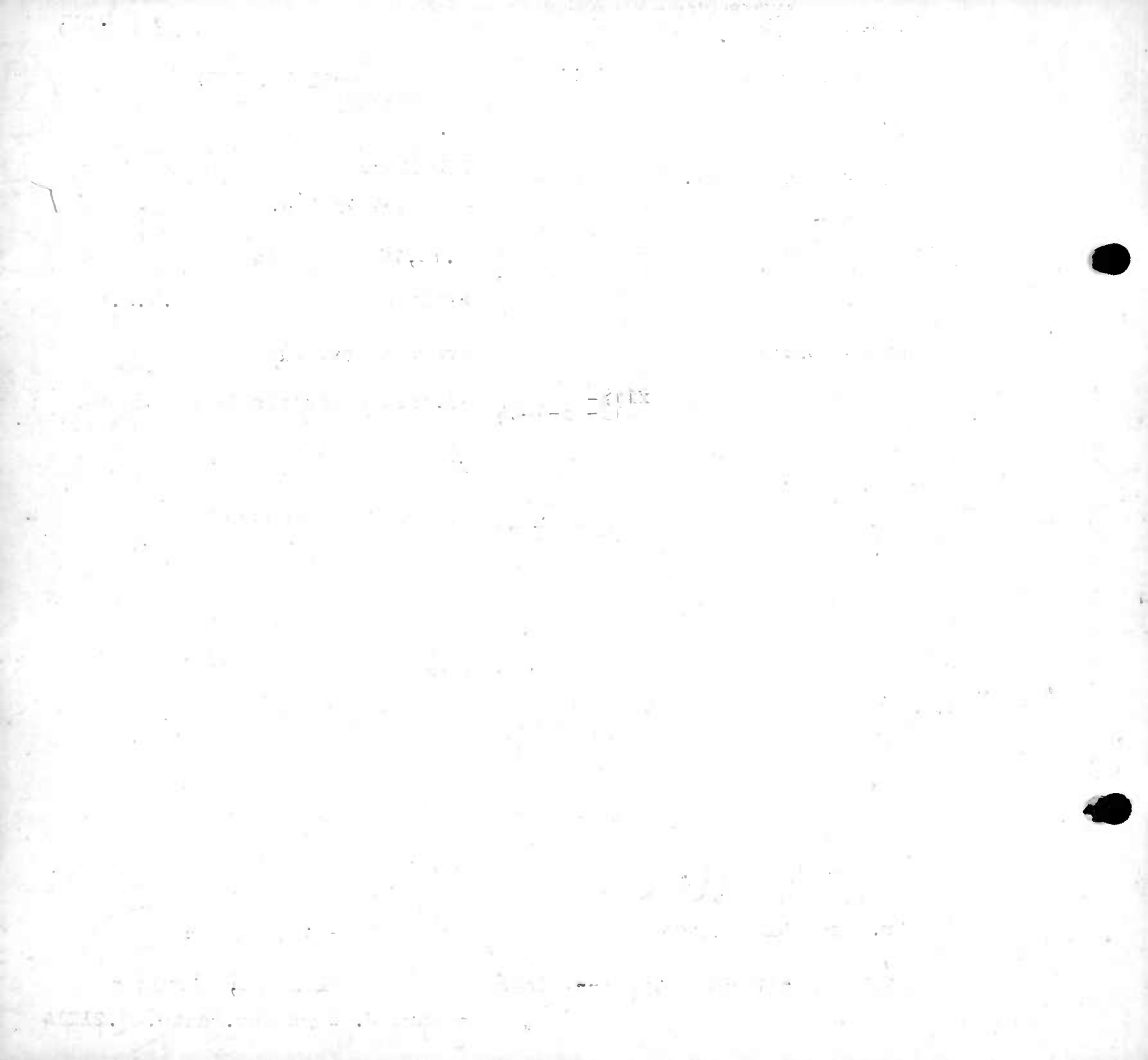
1975

1975

FUNERAL DIRECTOR: IMPORTANT

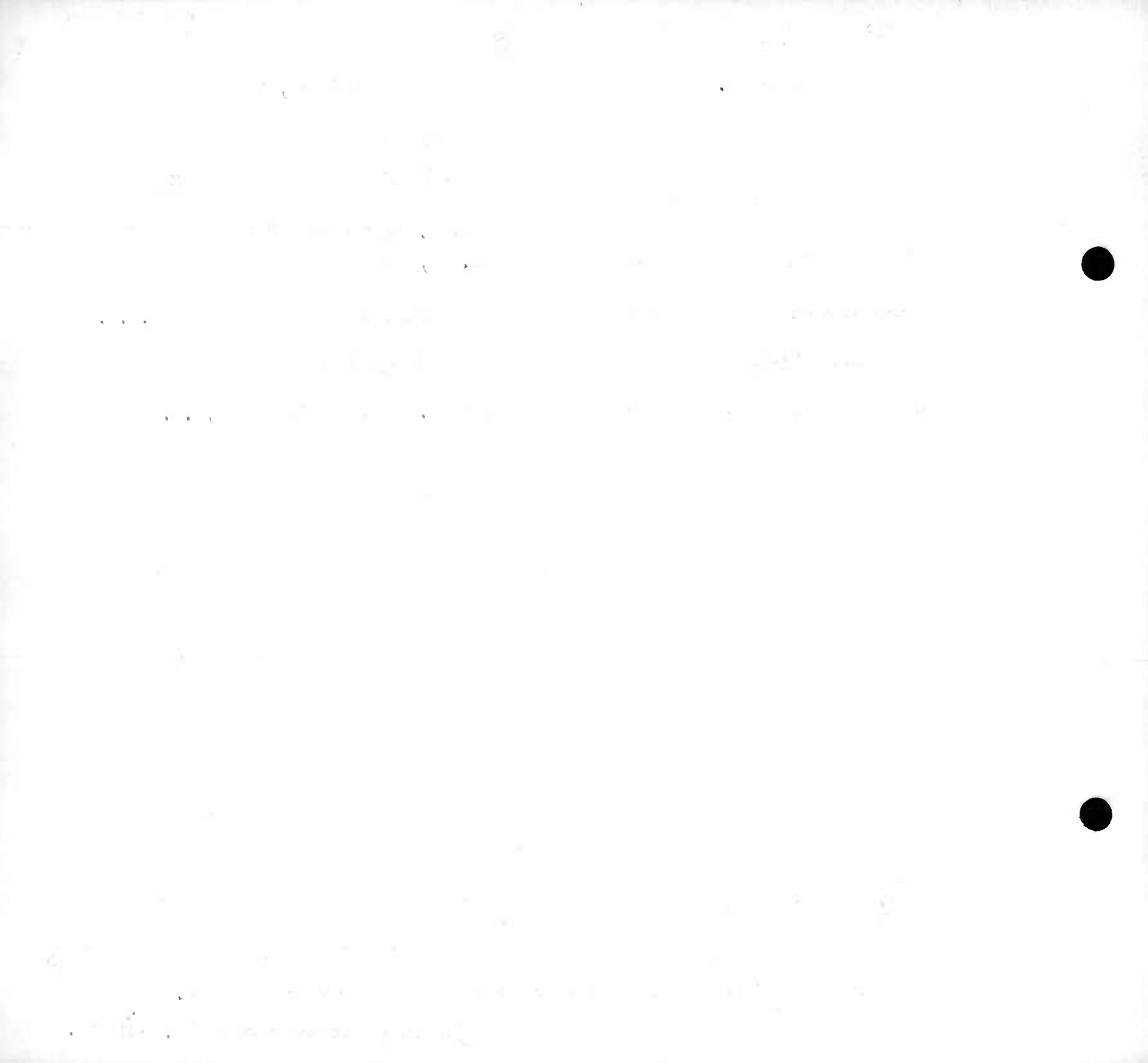
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>72 03685</u>	
B-242 72 03685		BIRTH NO.			
1. NAME OF DECEASED (Type or Print) FRANCES BACLAWSKI			2. DATE AND HOUR OF DEATH April 14, 1972		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 4815 Arabia Ave.			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY 2744		
			C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER 4815 Arabia A e.		
5. SEX Female	6. RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 16, 1907	9. AGE (In years lost birthday) 64	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Seamstress		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Anthony Janka			14. MOTHER'S MAIDEN NAME Frances Rozalska		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 224-213-03-1664	17. INFORMANT Richard A Baclawski		ADDRESS Same
18. I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH Arterio sclerosis with generalized arteriosclerosis (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 3 12 1968 to 4 12 1972 that (I) (we) last saw the deceased alive on 4 12 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Dr. Sebastian Russo				23B. DATE SIGNED 4/14/72	
23C. PHYSICIAN'S NAME (Type) Dr. Sebastian Russo				23D. ADDRESS 5122 Adolphus	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4/18/72		24C. NAME OF CEMETERY or CREMATORY St Stanislaus	
				24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. APR 18 1972		25B. NAME OF REGISTRAR Leonard J. Ruck		25C. FUNERAL DIRECTOR ADDRESS Inc. Balto. Md. 21214	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

K-610		72 03686		BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		72 03686	
BIRTH NO.				REG. NO.					
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH					
James H. Kirby				April 16, 1972					
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)					
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				A. STATE B. COUNTY					
90 Harbor View Nursing Home				Maryland		2302			
5. SEX		6. RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (in years last birthday)	
Male		White		WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		Jan. 26, 1892		80	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY	
Brewery worker				Brewery		Maryland		U.S.A.	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME					
Joseph Kirby				Ella Tydings					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
no				unknown		Grace M. Haynie		Rio Grande, N.J.	
18. CAUSE OF DEATH									
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				Dehydration, Malnutrition		Weeks			
ANTECEDENT CAUSES				(B) DUE TO, OR AS A CONSEQUENCE OF:		Years			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				Severe Peripheral Vase Disease with amputation of one leg, Gangrene of the other					
II									
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).									
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?					
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>							
22. I certify that (if this hospital) attended the deceased from 19 68 to 16 April 19 72 that (if we) last saw the deceased alive on 16 April 19 72 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (if we) (did) (did not) view the body after death.									
23A. SIGNATURE				23B. DATE SIGNED					
Peter H. Rheinsteen, M.D.				17 April 1972					
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS					
PETER H RHEINSTEIN, MD				HARBOR VIEW NURSING CENTER					
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY		24D. LOCATION (City, town, or county) (State)			
Burial		4/18/72		Cedar Hill Cemetery		Baltimore Md.			
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS			
APR 18 1972		Robert E. Kirby, M.D.		The Gully Funeral Home		130 E. Fort Ave.			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>72 03687</u>	
BIRTH NO. <u>M-620</u>		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <u>Morck, John C.</u>		2. DATE AND HOUR OF DEATH <u>4/15/72</u> <u>5</u> P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MD.</u> B. COUNTY <u>2505</u>			
FULL NAME OF HOSPITAL OR INSTITUTION <u>JOHNS HOPKINS HOSPITAL</u>		C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <u>M.</u> 6. RACE <u>C. W.</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>07-21-21</u> 9. AGE (in years last birthday) <u>50</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Crane operator</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Armco Steel</u>		11. BIRTHPLACE (State or foreign country) <u>Beth, Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>		13. FATHER'S NAME <u>deceased. MORCK, JOHN</u>		14. MOTHER'S MAIDEN NAME <u>deceased. MACNEARNEY, SADIE</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>Yes WWII 12-10-45 TO 12-3-45 TO</u>		16. SOCIAL SECURITY NO. <u>216 14 7445</u>		17. INFORMANT <u>WIFE</u>	
18. <u>571.0 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.		(A) IMMEDIATE CAUSE <u>Intestinal Bleed</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>Probable Alcoholic Liver Disease</u> DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>3 weeks</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>Yes</u>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>March 27</u> 19 <u>72</u> to <u>April 15</u> 19 <u>72</u> that (I) (we) last saw the deceased alive on <u>April 15</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>J. H. Varnell Jr.</u>		23B. DATE SIGNED <u>4/15/72</u>		23C. PHYSICIAN'S NAME (Type) <u>DR. J. H. VARNELL JR.</u>	
23D. ADDRESS <u>JOHNS HOPKINS HOSPITAL</u>					
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>4-19-72</u>		24C. NAME OF CEMETERY or CREMATORY <u>Holy Cross</u>	
24D. LOCATION (City, town, or county) (State) <u>Ridgely Hwy BALTO. MD.</u>					
25A. DATE REC'D BY HEALTH DEPT. <u>APR 18 1972</u>		25B. NAME OF REGISTRAR <u>Blair E. ...</u>		25C. FUNERAL DIRECTOR <u>MAHON</u>	
ADDRESS <u>24200 PENNINGTON AVE. 21226</u>					

74880 S.

31141 in 1954, 1955

1954-1955

1954-1955

1954-1955

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		72 03688	
K-620		72 03688	
BIRTH NO.		REG. NO.	
1. NAME OF DECEASED (Type or Print) KUREK, Mr. JOHN Joseph		2. DATE AND HOUR OF DEATH 4/10/72 3:55A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY 103	
FULL NAME OF HOSPITAL OR INSTITUTION Church Home & Hospital 100 North Broadway St.		C. CITY OR TOWN BALTIMORE, CITY D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER 526 S. KENWOOD AVE. 21224			
5. SEX MALE	6. RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/11/91
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED.		10B. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years lost birthday) 91
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? AMER.	
13. FATHER'S NAME JOHN KUREK		14. MOTHER'S MAIDEN NAME FRANCES STASIAK	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 215054032	
17. INFORMANT GERALDINE STEVENS		ADDRESS 947 PRINCETON TERR.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH 162.1 + 250.9 (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) slowing the UNDERLYING CONDITION lost.		CAUSE OF DEATH CARDIO RESPIRATORY FAILURE (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Ca of the LUNGS - Chronic Compensatory Heart Failure (B) DUE TO, OR AS A CONSEQUENCE OF: Arteriosclerotic cardiovascular (C) Diabetes Mellitus APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH immediately many years.	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, lorn, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 3/31/72 19 to 4/10/72 19 that (I) (we) last saw the deceased alive on 4/10/72 19 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE Walter J. Kaczorowski		23B. DATE SIGNED 4/10/72	
23C. PHYSICIAN'S NAME (Type) WALKER, A. INPHILIPATELLI		23D. ADDRESS 100 North Broadway St.	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE 4/14/72	
24C. NAME of CEMETERY or CREMATORY Holy Rosary Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore MD.	
25A. DATE REC'D BY HEALTH DEPT. APR 18 1972		25B. NAME OF REGISTRAR John E. Walker	
25C. FUNERAL DIRECTOR Walter J. Kaczorowski		ADDRESS 5525 Fleet St.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

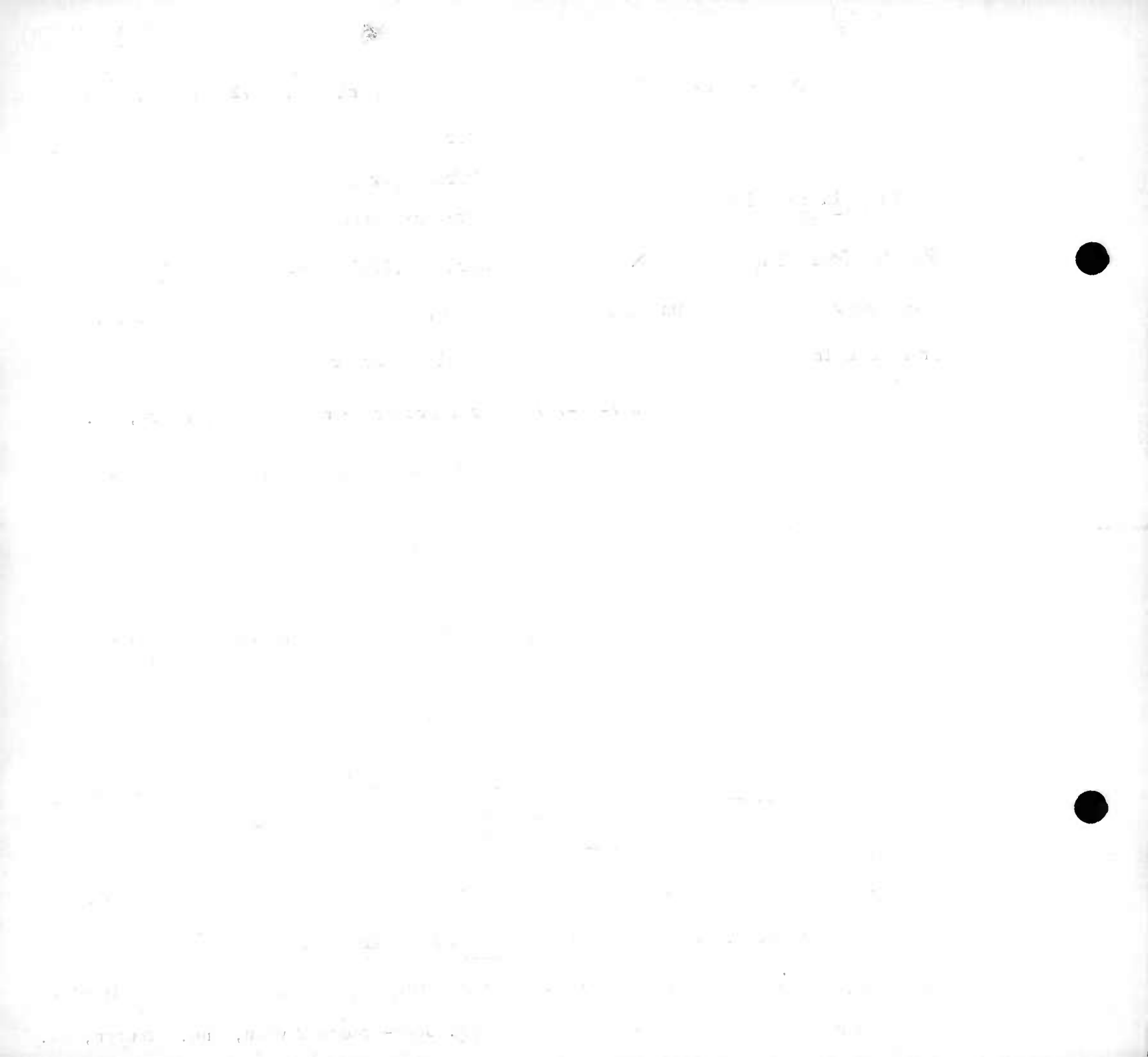
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 03689	
P-620 72 03689		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) JOHN J. PIROG		2. DATE AND HOUR OF DEATH April 9 1972			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION 00 603 S. LINWOOD AVE		A. STATE MARYLAND		B. COUNTY 102	
C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
E. STREET AND NUMBER 603 S. LINWOOD AVE					
5. SEX MALE	6. RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/4/1887	9. AGE (In years last birthday) 85	10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) POLAND	
12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME PETER PIROG		14. MOTHER'S MAIDEN NAME CAROLINE DUDEK			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 213-07-1271		17. INFORMANT MRS. FRANCES PIROG 603 S. LINWOOD	
18. 410.0 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Acute Coronary Infarction DUE TO, OR AS A CONSEQUENCE OF: (A) IMMEDIATE CAUSE Generalized Atherosclerosis DUE TO, OR AS A CONSEQUENCE OF: (B) HEV D. (C)		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Jan 1960 to April 9 1972 that (I) (we) last saw the deceased alive on April 8 1972 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Michael J. Janowski		23B. DATE SIGNED April 11, 1972			
23C. PHYSICIAN'S NAME (Type) M. J. JANOWSKI MD.		23D. ADDRESS 2711 EASTERN AVE.			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 4/13/72		24C. NAME OF CEMETERY or CREMATORY HOLY ROSARY CEMETERY	
24D. LOCATION (City, town, or county) (State) BALTIMORE MD.					
25A. DATE REC'D BY HEALTH DEPT. APR 18 1972		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR Richard A. Kaczorowski	
25D. ADDRESS 2525 FLEET ST.					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				72 03690	
CERTIFICATE OF DEATH				REG. NO. 72 03690	
BIRTH NO. <u>S-552</u>		1. NAME OF DECEASED (Type or Print) <u>MARTHA E. SIMMONS</u>			
2. DATE AND HOUR OF DEATH <u>April 14, 1972</u> <u>1:20</u> P.M.		3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>90 House in the Pines Bel-Aire</u>			
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>BALTO</u>		C. CITY OR TOWN <u>Upper Falls</u> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			
E. STREET AND NUMBER <u>Bradshaw Road</u>		5. SEX <u>Female</u> 6. RACE <u>Caucasian</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH <u>April 16, 1886</u> 9. AGE (In years last birthday) <u>85</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Home maker</u>			
11. BIRTHPLACE (State or foreign country) <u>Mass.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Frank Jenkins</u>		14. MOTHER'S MAIDEN NAME <u>Lilla Parkers</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>097-10-7576</u>		17. INFORMANT <u>Mrs. Arthur Dean</u> ADDRESS <u>Glen Arm. Rd.</u>	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Acute Lobar Pneumonia</u> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) <u>3 days</u>					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>Cachexia Chronic Brain Syndrome</u> <u>years</u>					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Indify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>4/7/72</u> to <u>4/14/72</u> that (I) (we) last saw the deceased alive on <u>4/13/72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) view the body after death.					
23A. SIGNATURE <u>Albert B. Bradley</u> DEGREE <u>MD</u>				23B. DATE SIGNED <u>4/15/72</u>	
23C. PHYSICIAN'S NAME (Type) <u>Albert B. Bradley</u>				23D. ADDRESS <u>4900 Belair Road</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>4-18-72</u>		24C. NAME OF CEMETERY or CREMATORY <u>Mt. Wollaston Cemetery Quincy</u>	
24D. LOCATION (City, town, or county) (State) <u>MASS.</u>		25A. DATE REC'D BY HEALTH DEPT. <u>APR 18 1972</u>			
25B. NAME OF REGISTRAR <u>Wm. Cook-Brooks</u>		25C. FUNERAL DIRECTOR ADDRESS <u>Towson, Md.</u>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
7-600 72 03691 CERTIFICATE OF DEATH					REG. NO. 72 03691				
BIRTH NO.		1. NAME OF DECEASED (Type or Print) FREY, ERNEST. WILLIAM			2. DATE AND HOUR OF DEATH April 15 1972				
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) UNION Memorial Hospital					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE BALTIMORE, MARYLAND 2719 C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 5505 WOODCREST AVENUE				
5. SEX Male	6. RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12-07-88	9. AGE (In years last birthday) 83	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Physician		10B. KIND OF BUSINESS OR INDUSTRY General Practice		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY U. S. A.			
13. FATHER'S NAME GEORGE FREY				14. MOTHER'S MAIDEN NAME EMMA MCCULLY					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 220 44 3584A		17. INFORMANT PABLO MELGAREJO M.D.		ADDRESS U. M. H.			
18. CAUSE OF DEATH 436.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> no		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR?		(If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from April 4 1972 to April 15 1972 that (I) (we) lost saw the deceased alive on April 15 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE Pablo Melgarejo				23B. DATE SIGNED 4-15-1972		23C. PHYSICIAN'S NAME (Type) Pablo Melgarejo			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 4-18-72		24C. NAME OF CEMETERY or CREMATORY Druid Ridge Cemetery		24D. LOCATION (City, town, or county) (State) Pikesville Md.			
25A. DATE REC'D BY HEALTH DEPT. APR 18 1972		25B. NAME OF REGISTRAR Robert J. Taylor		25C. FUNERAL DIRECTOR W. B. Gold		ADDRESS Books, Towson, Md.			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <u>72-00264</u>		BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		REG. NO. <u>72 03692</u>	
1. NAME OF DECEASED (Type or Print) <u>O'Donnell, John B.</u>				2. DATE AND HOUR OF DEATH <u>4-15-72</u> <u>3:25 p.m.</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Georgia</u> B. COUNTY <u>Albany</u>			
FULL NAME OF HOSPITAL OR INSTITUTION <u>Mercy Hospital</u> <u>37</u>		IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION		C. CITY OR TOWN <u>Albany</u>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <u>male</u>		6. RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1-3-72</u>	
9. AGE (In years last birthday) <u>3 mo 11</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11. BIRTHPLACE (State or foreign country) <u>Albany, Georgia MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>John B. O'Donnell</u>				14. MOTHER'S MAIDEN NAME <u>Denise Neal</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>John B. O'Donnell - 35 Dawson Drive</u>		ADDRESS	
18. <u>772.0 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH I (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>Cardiorespiratory arrest</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>Intracranial bleeding</u> DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION <u>4</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH? <input type="checkbox"/> (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>4/14/72</u> 19 <u>72</u> to <u>4/15</u> 19 <u>72</u> that (I) (we) last saw the deceased alive on <u>4/15</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>Eugenia B. Utzurum M.D.</u>				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <u>4/15/72</u>	
23C. PHYSICIAN'S NAME (Type) <u>EUGENIA B. UTZURUM M.D.</u>				23D. ADDRESS			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>4-18-72</u>		24C. NAME of CEMETERY or CREMATORY <u>Lorraine Park Cem.</u>		24D. LOCATION (City, town, or county) (State) <u>Woodlawn Ind.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>APR 18 1972</u>		25B. NAME OF REGISTRAR <u>John M. R.</u>		25C. FUNERAL DIRECTOR <u>Harley C. ...</u>		ADDRESS <u>F. H. ...</u>	

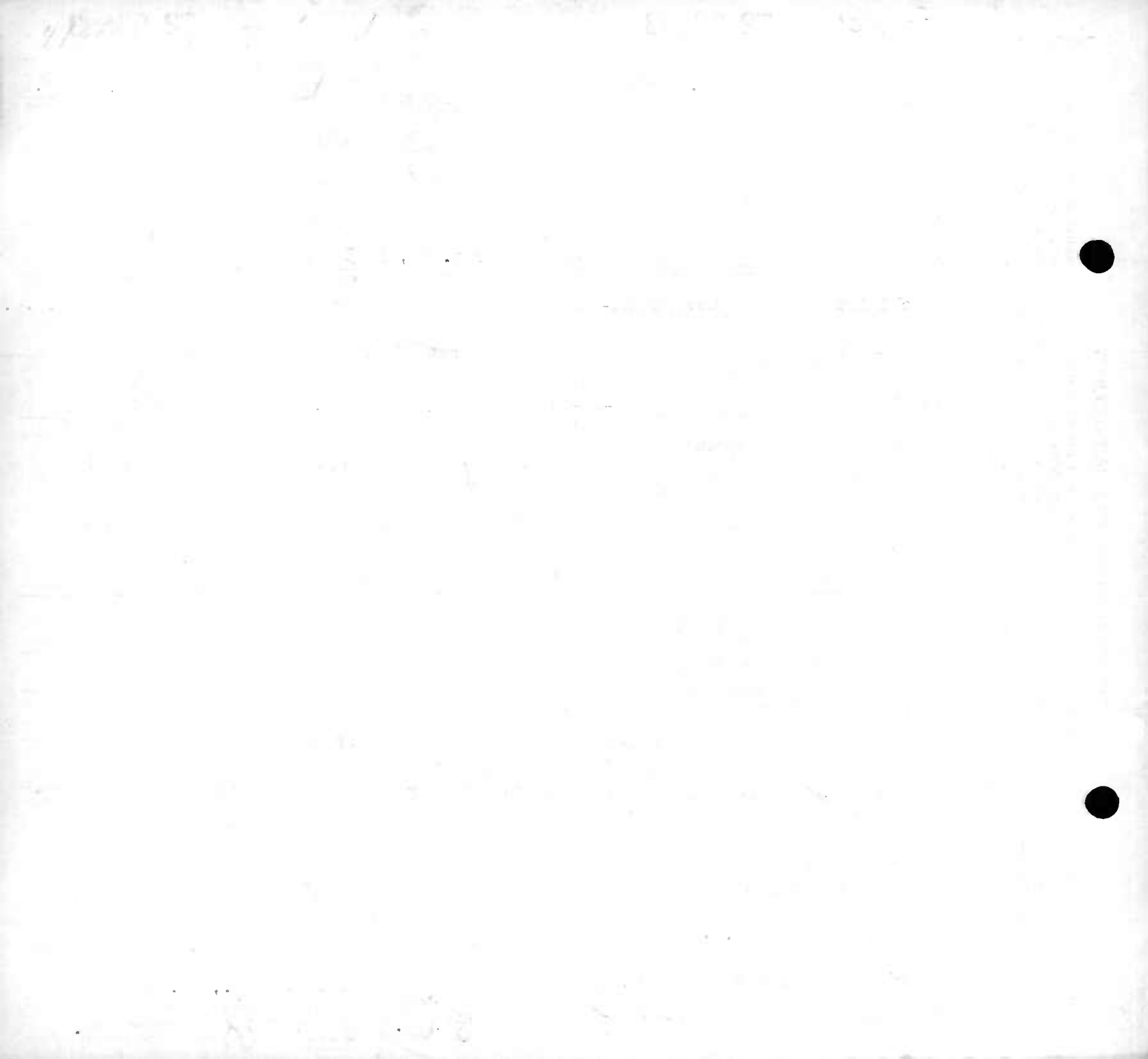


48-11-28

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

E-640		72 03693		BALTIMORE CITY HEALTH DEPARTMENT		X		REG. NO. 72 03693			
BIRTH NO.				1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH			
				Charles E. Earle				April 13, 1972 11:45 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)							
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				A. STATE Maryland				B. COUNTY Baltimore			
Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland 21224				C. CITY OR TOWN Essex				D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
E. STREET AND NUMBER 1644 Eastern Avenue 21224											
5. SEX Male		6. RACE Caucasian		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept. 30, 1893		9. AGE (in years lost birthday) 78		If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machinist				10B. KIND OF BUSINESS OR INDUSTRY Government-Edgewood Arsenal, Md. Maryland				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME John Earle				14. MOTHER'S MAIDEN NAME Emma ?							
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. 216-11-6732		17. INFORMANT 4940 Eastern Avenue BCH: RECORDS Baltimore, Maryland 21224				ADDRESS	
18. CAUSE OF DEATH								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteonia, etc. It means the disease, injury or complication which caused death.)				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Pneumonia				1d			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) DUE TO, OR AS A CONSEQUENCE OF: COPD & Acute Bronchitis				3d			
				(C) Trifascicular block				2 yrs			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				Chronic Bronchitis				10 yrs			
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)							
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?							
22. I certify that (X) (this hospital) attended the deceased from 4/9/72 19 to 4/13 1972 that (I) (we) last saw the deceased alive on 4/13 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (X) (We) (did) (did not) view the body after death.											
23A. SIGNATURE Joel Chasis M.D.				23B. DATE SIGNED 4/15/72							
23C. PHYSICIAN'S NAME (Type) Joel Chasis M.D.				23D. ADDRESS Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland 21224							
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4/17/72		24C. NAME of CEMETERY or CREMATORY Parkwood Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore Co., Md.					
25A. DATE REC'D BY HEALTH DEPT. APR 18 1972		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR James E. Brudzinski		25D. ADDRESS 1407 Eastern Ave.					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embolmed or final disposition is made.

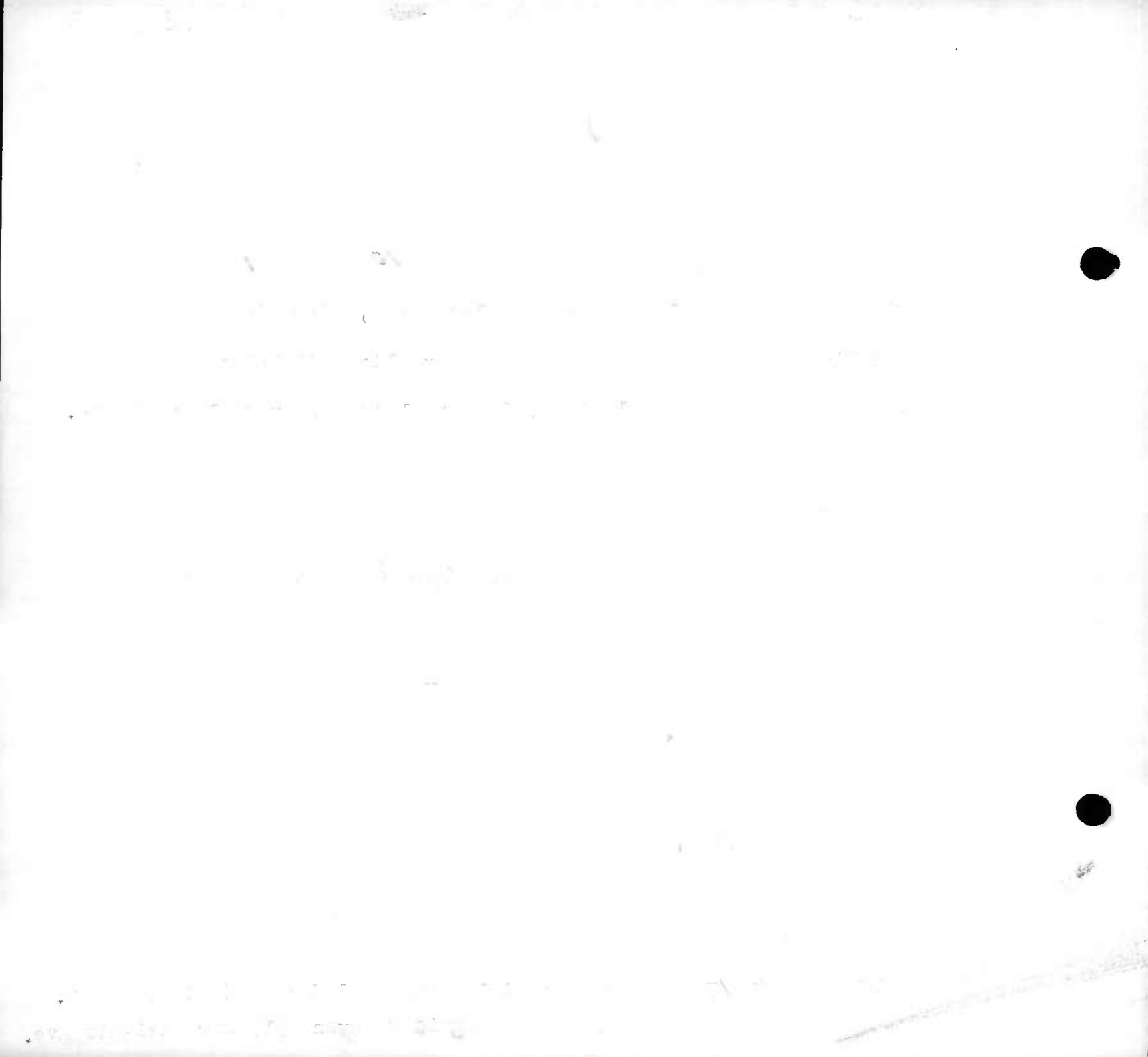
Baltimore City Health Department				REG. NO. 72 03694	
<div style="display: flex; justify-content: space-between;"> E-524 72 03694 CERTIFICATE OF DEATH </div>					
BIRTH NO.		1. NAME OF DECEASED (Type or Print) JOHN ENGEL SR		2. DATE AND HOUR OF DEATH APRIL 5. 72 M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD B. COUNTY 2748		
FULL NAME OF HOSPITAL OR INSTITUTION 00 1324 E. BELVEDERE AV.			C. CITY OR TOWN BALTO		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			E. STREET AND NUMBER 1324 BELVEDERE AV.		
5. SEX M.	6. RACE W.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/20/191	9. AGE (In years lost birthday) 81	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) BALTO	
13. FATHER'S NAME Heinrich			14. MOTHER'S MAIDEN NAME UNKNOWN		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) —		16. SOCIAL SECURITY NO.		17. INFORMANT SON 165 SPRINGSIDE DR.	
18. 442X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Agad.			CAUSE OF DEATH Rupt'd Aneurysm		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (i) (this hospital) attended the deceased from 1960 to Present 19 4/1/72 and that (i) (we) last saw the deceased alive on 4/1/72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE [Signature]				23B. DATE SIGNED 4/7/72	
23C. PHYSICIAN'S NAME (Type) [Signature]				23D. ADDRESS 200 E. Joppa Rd	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE 4/8/72		24C. NAME of CEMETERY or CREMATORY IMMANUEL	
BURIAL		4/8/72		BALTO MD	
25A. DATE REC'D BY HEALTH DEPT. APR 18 1972		25B. NAME OF REGISTRAR Robert E. [Signature]		25C. FUNERAL DIRECTOR BARTHELMANN 6067 HARTFORD RD	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		72 03695		REG. NO. 72 03695	
BIRTH NO. <u>M-235</u>		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <u>Mc DANIEL, Lily May</u>		2. DATE AND HOUR OF DEATH <u>4/14/72</u> <u>10:05 A.M.</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <u>SINAI HOSP. OF BALTIMORE, INC.</u>		A. STATE <u>Maryland</u>		B. COUNTY <u>2788</u>	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
<u>42</u>		E. STREET AND NUMBER <u>5204 Denmore Ave.</u>			
5. SEX <u>F</u>	6. RACE <u>N N</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4/21/10</u>	9. AGE (in years last birthday) <u>61</u>	10. Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Self Employed</u>		11. BIRTHPLACE (State or foreign country) <u>Blackstone, Virginia</u>	
13. FATHER'S NAME <u>William Epps</u>		14. MOTHER'S MAIDEN NAME <u>Mary Elizabeth Gates</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>214 24 9743</u>		17. INFORMANT ADDRESS <u>Mrs Elaine Casey 3401 Paton Ave.</u>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <u>162.1 + 250.9</u>		CAUSE OF DEATH			
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Cerebro-vascular accident 1 week</u>			
		(B) DUE TO, OR AS A CONSEQUENCE OF: <u>Lung CA? & possible brain metastases 3 weeks</u>			
		(C) <u>Sepsis - Aspiration pneumonia</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		<u>Diabetes Mellitus</u>			
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>yes</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>3-20</u> 19 <u>72</u> to <u>4-14</u> 19 <u>72</u> that (I) (we) last saw the deceased alive on <u>4-14</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Veneranda C. Gerasimio M.D.</u>				23B. DATE SIGNED <u>4/14/72</u>	
23C. PHYSICIAN'S NAME (Type) <u>Veneranda C. Gerasimio</u>				23D. ADDRESS <u>Sinai Hosp. of Baltimore Inc.</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>4/18/72</u>		24C. NAME of CEMETERY or CREMATORY <u>Arbutus Memorial Park</u>	
24D. LOCATION <u>Baltimore (Balto)</u>		24E. ADDRESS <u>Md.</u>			
25A. DATE REC'D BY HEALTH DEPT. <u>APR 18 1972</u>		25B. NAME OF REGISTRAR <u>John J. ...</u>		25C. FUNERAL DIRECTOR <u>Lewis T. G. ...</u>	
				ADDRESS <u>4517 Park Heights Ave.</u>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>72 03696</u>
BIRTH NO. <u>B-655</u>		72 03696		CERTIFICATE OF DEATH
1. NAME OF DECEASED (Type or Print) <u>DAVID BRANNON</u>		2. DATE AND HOUR OF DEATH <u>4-8-72</u> <u>3:45</u> P.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>Lake Drive Conv. Home</u>		A. STATE <u>MD</u> B. COUNTY <u>Harford</u>		
		C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>
		E. STREET AND NUMBER <u>White Oak & Eutaw Place</u>		
5. SEX <u>M</u>	6. RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept 16, 1876</u>	9. AGE (In years last birthday) <u>95</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Ill. O.</u>
13. FATHER'S NAME <u>James Brannon</u>		14. MOTHER'S MAIDEN NAME <u>E. L. Apple</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>216-12-0105</u>		17. INFORMANT <u>MRS. DOROTHY MAJORS MONACA, PA.</u>
18. <u>412.4 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <u>CARDIAC ARREST (Sudden.)</u> (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>II</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <u>Arteriosclerotic cerebrovascular disease & A.S.C.U.D. =</u> <u>Arteriosclerotic cerebrovascular disease & A.S.C.U.D. =</u> <u>Arteriosclerotic cerebrovascular disease & A.S.C.U.D. =</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>NO</u>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from <u>12-20</u> 19 <u>69</u> to <u>4-8</u> 19 <u>72</u> that (I) (we) last saw the deceased alive on <u>4-6</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <u>M. Blum</u>		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <u>4-8-72</u>
23C. PHYSICIAN'S NAME (Type) <u>MAURICIO F. ALBUERNE MD</u>		23D. ADDRESS <u>7935 PIPERS PATH RAN BURNIE MD 21051</u>		
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>	24B. DATE <u>4/10/72</u>	24C. NAME OF CEMETERY OR CREMATORY <u>Mt. Calvary Cemetery</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore (AA Co.) Md.</u>
25A. DATE REC'D BY HEALTH DEPT. <u>APR 18 1972</u>		25B. NAME OF REGISTRAR <u>John E. Taylor</u>		25C. FUNERAL DIRECTOR <u>LEWIS T. GWYNN</u> ADDRESS <u>4517 PARK HEIGHTS AVE.</u>

In Bolton Hill prior to this N.H.

No Prev. address available.

enroll v.m. (Lake Drive) Car. House

enroll (Lake Drive) Car. House
enroll (Lake Drive) Car. House

22 16/1872

O.H.O.

2/15. Apple

James L. Brown
James L. Brown

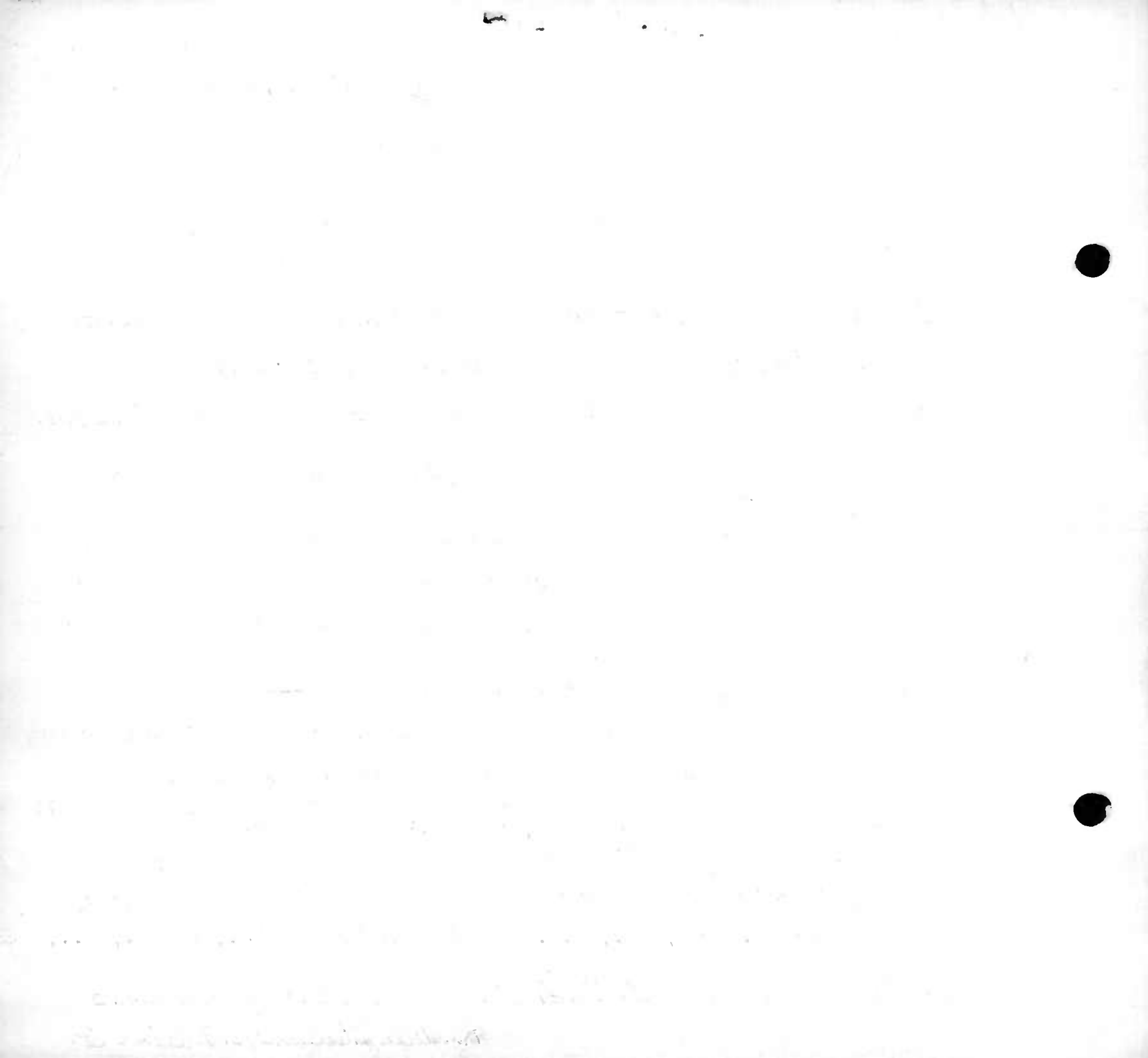
2-10-13-012

24.1 5-1-012

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

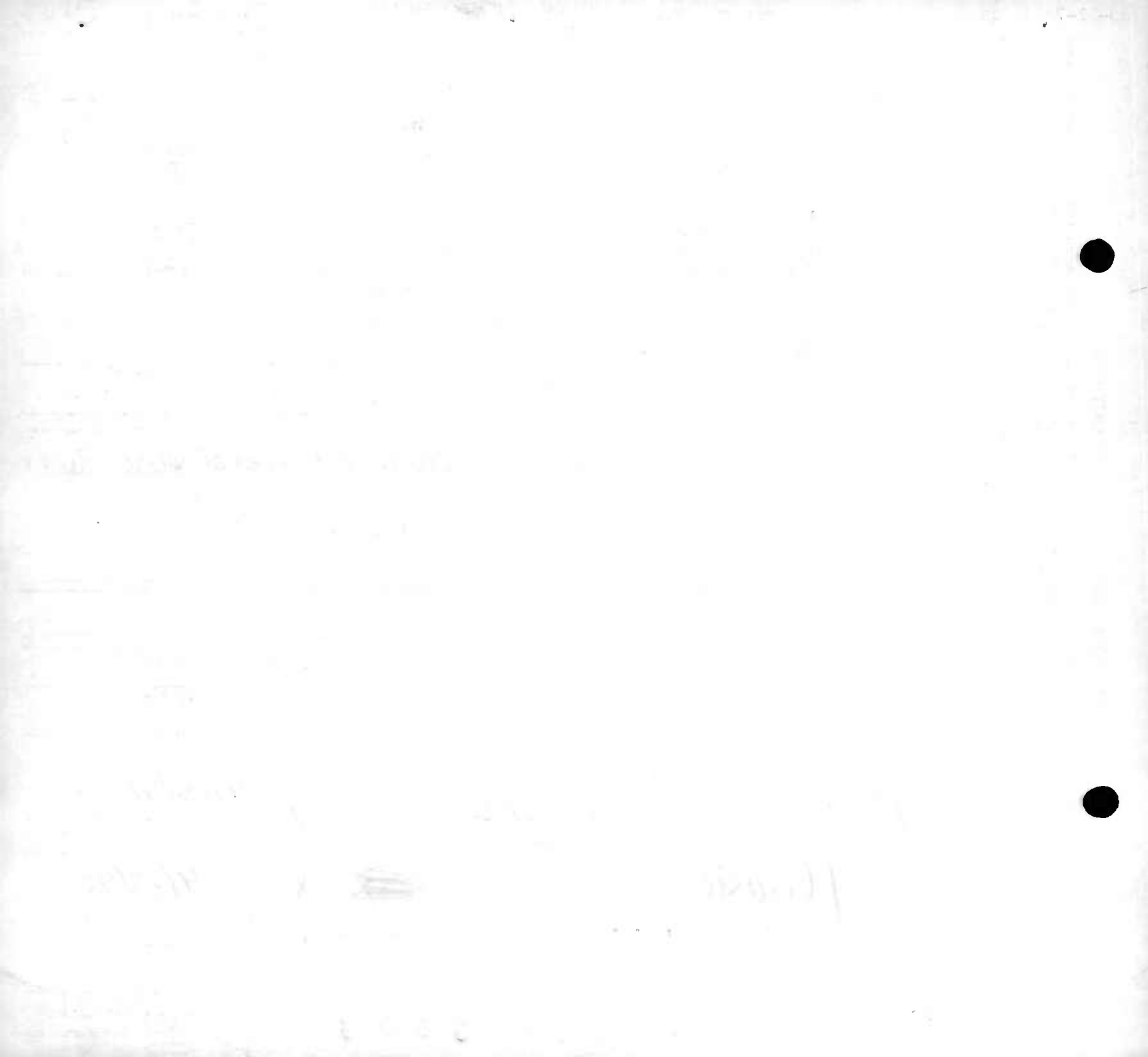
BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. <u>72 03697</u>
<u>S-552</u> <u>72 03697</u> BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>Blanche Simmons</u>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <u>45</u> <u>GOOD SAMARITAN HOSPITAL</u>		2. DATE AND HOUR OF DEATH <u>April 15, 1972</u> <u>4:00 AM</u>		
5. SEX <u>F</u> 6. RACE <u>B</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>BALTIMORE</u> <u>843</u> C. CITY OR TOWN <u>BALTIMORE</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>1214 EDISON HIGHWAY</u>		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>		
11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>JOHN DOCK</u>		14. MOTHER'S MAIDEN NAME <u>EMMA PRESTON</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>?</u>		
17. INFORMANT <u>Mrs Mary Medley</u>		ADDRESS <u>1363 Pentridge Rd.</u>		
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of death, but the disease, heart failure, asthma, etc., which caused the death, injury or condition which caused death.) <u>pulmonary edema</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>myocardial infarction</u> DUE TO, OR AS A CONSEQUENCE OF: (C) <u>generalized atherosclerosis</u> DUE TO, OR AS A CONSEQUENCE OF: (D) <u>Fracture of Femur</u> <u>urinary tract infection</u>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>3 hours</u> <u>1 week</u> <u>5 years</u> <u>2 weeks</u>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <u>fracture of left femur</u>				
19A. DATE OF OPERATION <u>3/28/72</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>fracture of left femur</u>		
20A. AUTOPSY? (Yes or No) <u>no</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>---</u>		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indify medical examiner) <u>---</u>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>home</u>		
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <u>fell at home, 1214 Edison Highway</u>		21D. TIME OF INJURY (Approx.) <u>3 26 72 8PM</u>		
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? <u>patient fell unattended</u>		
22. I certify that (I) (this hospital) attended the deceased from <u>April 13</u> 19 <u>72</u> to <u>April 15</u> 19 <u>72</u> that (I) (we) last saw the deceased alive on <u>April 15, 1972</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.				
23A. SIGNATURE <u>George H. Sack, Jr.</u> <u>MD</u>				23B. DATE SIGNED <u>4/15/72</u>
23C. PHYSICIAN'S NAME (Type) <u>George H. Sack, Jr., M.D.</u>				23D. ADDRESS <u>5601 Loch Raven Blvd., Balto., Md., 212</u>
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>4-18-72</u>		
24C. NAME OF CEMETERY OR CREMATORY <u>Gardens of Eternal Hope</u>		24D. LOCATION (City, town, or county) (State) <u>FINKSBURG, MARYLAND</u>		
25A. DATE REC'D BY HEALTH DEPT. <u>APR 18 1972</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor, M.D.</u>		
25C. FUNERAL DIRECTOR <u>Robert E. Taylor, M.D.</u>		ADDRESS <u>2431 E. Oliver St.</u>		



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <i>M-214</i>				BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. <i>72 03698</i>	
1. NAME OF DECEASED (Type or Print) <i>Maxfield, John R.</i>				2. DATE AND HOUR OF DEATH <i>4/14/72 4:15 PM</i>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <i>Baltimore City Hospital</i> <i>31 4940 Eastern Avenue</i> <i>Baltimore, Maryland 21224</i>				A. STATE <i>Maryland</i> B. COUNTY <i>908</i>			
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				C. CITY OR TOWN <i>Baltimore</i>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <i>1900 Homewood Ave.</i>			
5. SEX <i>m</i>	6. RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>2-2-04</i>	9. AGE (In years last birthday) <i>68</i>	If Under 1 Yr. Months Days	If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY <i>USA</i>	
13. FATHER'S NAME <i>John Samuel Maxfield</i>				14. MOTHER'S MAIDEN NAME <i>Ellen Murray</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT BCH RECORDS: <i>4940 Eastern Avenue 21224</i>			
18. <i>440.9 I</i> CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Ischemic bowel disease 3 wks</i>			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) <i>Generalized arteriosclerosis</i> DUE TO, OR AS A CONSEQUENCE OF:			
(C) _____							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>NO</i>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) I (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (1) (this hospital) attended the deceased from <i>4/13/72</i> 19 to <i>4/15/72</i> 19 that (1) (we) last saw the deceased alive on <i>4/13/72</i> 19 and that (1) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <i>Chasis</i>				23B. DATE SIGNED <i>4/13/72</i>		23C. PHYSICIAN'S NAME (Type) <i>Joel Ann Chasis, M.D.</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>4-18-72</i>		24C. NAME of CEMETERY or CREMATORY <i>Mt. Auburn Cem.</i>		24D. LOCATION (City, town, or county) (State) <i>Balt Md.</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>APR 18 1972</i>		25B. NAME OF REGISTRAR <i>Robert E. Fisher</i>		25C. FUNERAL DIRECTOR <i>WMC MARCH</i>		ADDRESS <i>928 E NORTH AVE</i>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

<div style="display: flex; justify-content: space-between;"> S-356 72 03699 </div>		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		72 03699 REG. NO. _____	
1. NAME OF DECEASED (Type or Print) IRENE O. SYMON			2. DATE AND HOUR OF DEATH 4-14-72 7:50 P.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) LUTHERAN HOSPITAL OF MD. INC 46 730 ASHBURTON ST			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE _____ B. COUNTY _____ C. CITY OR TOWN BALTIMORE MD D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 1700 HOLBROOK ST		
5. SEX F	6. RACE N	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-29-07	9. AGE (in years last birthday) 65	If Under 1 Yr. Months: _____ Days: _____ If Under 24 Hrs. Hours: _____ Min. _____
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED			11. BIRTHPLACE (State or foreign country) MARYLAND		
13. FATHER'S NAME PAUL SHARPS			14. MOTHER'S MAIDEN NAME (SHARPS) CECILIA EVANS		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS ROBERT - HUSBAND SAME
18. 4369 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CARDIAC FAILURE ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. ACCIDENT CEREBRO-VASCULAR FAILURE			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 4-2-1972 to 4-14-1972 that (I) (we) last saw the deceased alive on 4-14-1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE [Signature] MD.			23B. DATE SIGNED 4-14-72		23C. PHYSICIAN'S NAME (Type) SAMUEL J. EDWIN MD.
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 4-19-72		24C. NAME OF CEMETERY OR CREMATORY BALTO. CEMETERY	
24D. LOCATION (City, town, or county) BALTO. MD		24E. NAME OF REGISTRAR [Signature]		24F. FUNERAL DIRECTOR ADDRESS 928 E NORTH AVE	
25A. DATE REC'D BY HEALTH DEPT. APR 18 1972		25B. NAME OF REGISTRAR [Signature]		25C. FUNERAL DIRECTOR ADDRESS 928 E NORTH AVE	



BALTIMORE CITY HEALTH DEPARTMENT
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) JONNIE YOUNG		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 00 2123 Bolton Street		3. DATE PRONOUNCED DEAD Month Day Year Hour March 15, 1972 7:15 A.M.	
6. SEX Male		7. RACE Negro	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
9. DATE OF BIRTH 35		10. AGE (In years lost birth day) 35	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		14B. KIND OF BUSINESS OR INDUSTRY	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO.	
18. INFORMANT		ADDRESS	

19. 304.7 CAUSE OF DEATH Intravenous narcotism DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc., it means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22D. TIME OF INJURY (Approx.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		22F. HOW DID INJURY OCCUR?	

23. I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE *Charles S. Springate* M.D. DATE SIGNED **March 15, 1972**

EXAMINER'S NAME (Type) **Charles S. Springate, M.D.**

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE 4-14-72	24C. NAME OF CEMETERY or CREMATOR	24D. LOCATION (City, town, or county) (State)
25A. DATE REC'D BY HEALTH DEPT. APR 18 1972	25B. NAME OF REGISTRAR Robert E. Taylor, M.D.	25C. FUNERAL DIRECTOR	

**ANATOMY BOARD OF MARYLAND
UNIVERSITY MEDICAL SCHOOL
MORTUARY SERVICE - BCHD**

5-1-1972 - Completion of cause of death on a pending medical examiner death certificate

Charles S. Springate, M.D.

HRS

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

72 03701

BIRTH NO.

1. NAME OF DECEASED (Type or Print) WALTER SPRINKLE		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> 3 19 1972 Hour 4:35p M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 00 4012 Maine Ave.		3. DATE PRONOUNCED DEAD Month Day Year 3 19 1972 Hour 4:35p M.	
6. SEX male		7. RACE white	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY 1510	
9. DATE OF BIRTH		10. AGE (In years lost birthday) 65 If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		14B. KIND OF BUSINESS OR INDUSTRY	
15. MOTHER'S MAIDEN NAME		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	
17. SOCIAL SECURITY NO.		18. INFORMANT ADDRESS	
19. 412.4 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		CAUSE OF DEATH Arteriosclerotic cardiovascular disease (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?		22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Russell S. Fisher M.D. EXAMINER'S NAME (Type) Russell S. Fisher, M.D. CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 3-20-82			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE 4-14-72	
24C. NAME OF CEMETERY OR CREMATORY		24D. LOCATION (City, town, or county) (State)	
25A. DATE REC'D BY HEALTH DEPT. APR 18 1972		25B. NAME OF REGISTRAR Robert E. Fisher, M.D.	
25C. FUNERAL DIRECTOR		25D. ADDRESS	

ANATOMY BOARD OF MARYLAND
UNIVERSITY MEDICAL SCHOOL
MORTUARY SERVICE - BCHD

1710 S

1000 S

WALLLEY 1101161

WALLLEY 1101161

U-525

72 03702

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

72 03702

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

UNKNOWN

2. DATE
OF DEATHKnown ☒ Estimated ☐Month
1Day
13Year
72Hour
M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL
OR INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

00 20 North Pine Street

3. DATE
PRONOUNCED DEADMonth
1Day
13Year
72Hour
3:15 p.m.5. USUAL RESIDENCE (Where deceased lived; if institution: residence before admission)
A. STATE B. COUNTY

6. SEX

male

7. RACE

Negro

8. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☐DIVORCED ☐

C. CITY OR TOWN

D. INSIDE CITY LIMITS?

YES ☐ NO ☐

9. DATE OF BIRTH

10. AGE (In years
last birthday)If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

E. STREET AND NUMBER

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

14A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)17. SOCIAL
SECURITY NO.

18. INFORMANT

ADDRESS

19. 412.4 I

CAUSE OF DEATH

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

Arteriosclerotic cardiovascular disease

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART I (A).

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

yes

22A. EXTERNAL CAUSE WAS
UNDERLYING ☐ OR CONTRIB-
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg., etc.)22C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?22D. TIME (Month) (Day) (Year) (Hour)
OF INJURY
(APPROX.)22E. INJURY OCCURRED
WHILE AT ☐ NOT WHILE
WORK ☐ AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Peter Lipkovic, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

1/14/72

24A. BURIAL CREMATION,
REMOVAL (Specify)

24B. DATE

4-11-72

24C. NAME OF CEMETERY

ANATOMY BOARD OF MARYLAND (State)

25A. DATE REC'D BY HEALTH DEPT.

25B. NAME OF REGISTRAR

25C. FUNERAL DIRECTOR

ADDRESS

APR 18 1972

Robert E. Fisher, M.D.

UNIVERSITY MEDICAL SCHOOL

MORTUARY SERVICE - BCHD

35 03 57

35 03 57

35 03 57

35 03 57

35 03 57

35 03 57

W-320

72 03703

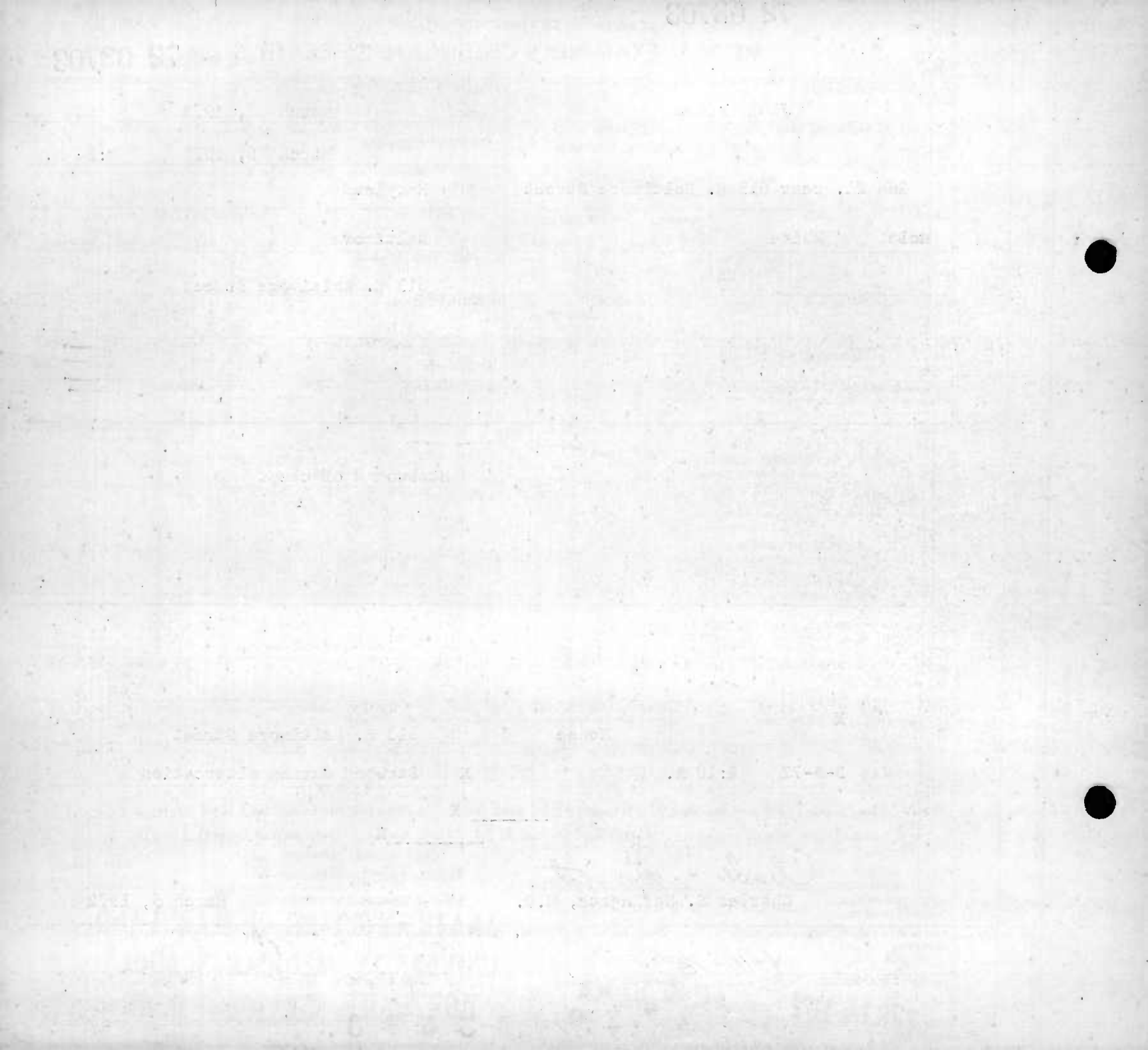
BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 72 03703

BIRTH NO.

1. NAME OF DECEASED (Type or Print) JACK WOODS		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> March 5, 1972 M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 00 2nd fl. rear 613 E. Baltimore Street		3. DATE PRONOUNCED DEAD Month Day Year Hour March 5, 1972 2:30 A.M.	
5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 401		C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
6. SEX Male	7. RACE White	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH 10. AGE (In years last birthday) 47		11. BIRTHPLACE (State or foreign country)	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		14B. KIND OF BUSINESS OR INDUSTRY	
15. MOTHER'S MAIDEN NAME		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	
17. SOCIAL SECURITY NO.		18. INFORMANT ADDRESS	
19. E966X1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		CAUSE OF DEATH (A) IMMEDIATE CAUSE Stabwound of chest DUE TO, OR AS A CONSEQUENCE OF: (B) _____ DUE TO, OR AS A CONSEQUENCE OF: (C) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) Yes		22A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.	
22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) House		22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 613 E. Baltimore Street	
22D. TIME OF INJURY (APPROX.) 3-5-72 2:10 A.M.		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	
22F. HOW DID INJURY OCCUR? Stabbed during altercation		23.	
I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Charles S. Springate M.D. EXAMINER'S NAME (Type): Charles S. Springate, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED March 5, 1972	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE 4-11-72	
24C. NAME OF CEMETERY		24D. LOCATION (City, town, or county) (State)	
25A. DATE REC'D BY HEALTH DEPT. APR 18 1972		25B. NAME OF REGISTRAR Robert C. [illegible]	
25C. FUNERAL DIRECTOR MORTUARY SERVICE - BCHD		25D. ADDRESS	



1

W-425 72 03704 BALTIMORE CITY HEALTH DEPARTMENT MEDICAL EXAMINER'S CERTIFICATE OF DEATH 72 03704

BIRTH NO. REG. NO.

1. NAME OF DECEASED (Type or Print) James Wilson		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month 3 Day 6 Year 72 Hour M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION Maryland General Hospital		3. DATE PRONOUNCED DEAD Month 3 Day 6 Year 72 Hour 11:40 a. M.	
6. SEX male		7. RACE White	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Balto.	
9. DATE OF BIRTH 10. AGE (In years lost birthday) 47		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
11. BIRTHPLACE (State or foreign country)		E. STREET AND NUMBER 15 W. 24th Street	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		14B. KIND OF BUSINESS OR INDUSTRY	
15. MOTHER'S MAIDEN NAME			
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO.	
18. INFORMANT		ADDRESS	
19. 571.8 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Fatty metamorphosis of liver ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) yes			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?			
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE: Peter Lipkovic, M.D. EXAMINER'S NAME (Type) DATE SIGNED: 3/7/72			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE 4-11-72	
24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town or county or State)	
25A. DATE REC'D BY HEALTH DEPT. APR 18 1972		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.	
25C. FUNERAL DIRECTOR		25D. ADDRESS	

ANATOMY BOARD OF MARYLAND
UNIVERSITY MEDICAL SCHOOL
MORTUARY SERVICE - BCHD

VS 151-REV. 1/1/68

10780 ST

10780 ST



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

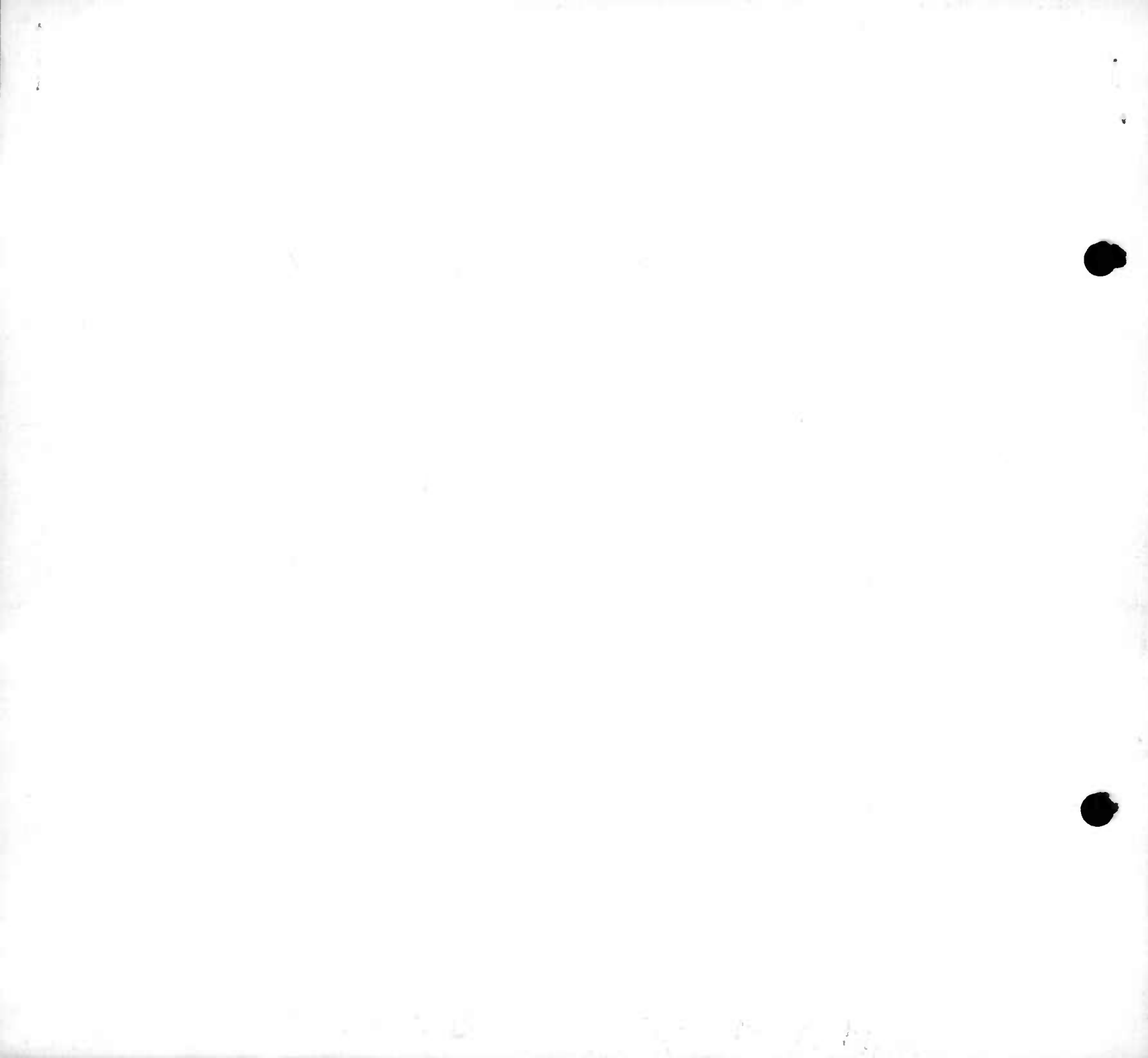
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>72 03705</u>					
BIRTH NO. <u>0-352</u> 1. NAME OF DECEASED (Type or Print) <u>BABY GIRL ODONS</u>		CERTIFICATE OF DEATH							
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>LUTHERAN HOSPITAL OF MARYLAND</u> <u>46</u>		2. DATE AND HOUR OF DEATH <u>MARCH 25, 1972</u> <u>1:00</u> A. M. 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>md.</u> B. COUNTY <u>md.</u> C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>3708 Cranston Ave</u> <u>730 Ashburton St.</u> <u>21229</u>							
5. SEX <u>F</u>	6. RACE <u>Black</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>MARCH 21, 1972</u>	9. AGE (In years last birthday) <table border="1" style="width: 100%;"> <tr> <td>II Under 1 Yr.</td> <td>II Under 24 Hrs.</td> </tr> <tr> <td>Months: <u>3</u></td> <td>Days: <u>6</u></td> </tr> </table>	II Under 1 Yr.	II Under 24 Hrs.	Months: <u>3</u>	Days: <u>6</u>
II Under 1 Yr.	II Under 24 Hrs.								
Months: <u>3</u>	Days: <u>6</u>								
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?				
13. FATHER'S NAME <u>Wilbert Lionel Anderson</u>			14. MOTHER'S MAIDEN NAME <u>BLONDELL ODONS</u>						
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS					
18. CAUSE OF DEATH									
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH (A) IMMEDIATE CAUSE <u>CARDIO - RESPIRATORY ARREST</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>PREMATURITY</u> DUE TO, OR AS A CONSEQUENCE OF: (C)					
II									
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).									
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from <u>March 21</u> 19 <u>72</u> to <u>March 25</u> 19 <u>72</u>. that (I) (we) lost saw the deceased alive on <u>March 25</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <u>[Signature]</u>				23B. DATE SIGNED <u>March 25, 1972</u>					
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS					
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <u>4-10-72</u>		24C. NAME of CEMETERY or CREMATORY					
24D. LOCATION (City, town, or county)		24E. STATE							
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR					
ANATOMY BOARD OF MARYLAND UNIVERSITY MEDICAL SCHOOL MORTUARY SERVICE - BCHD									



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

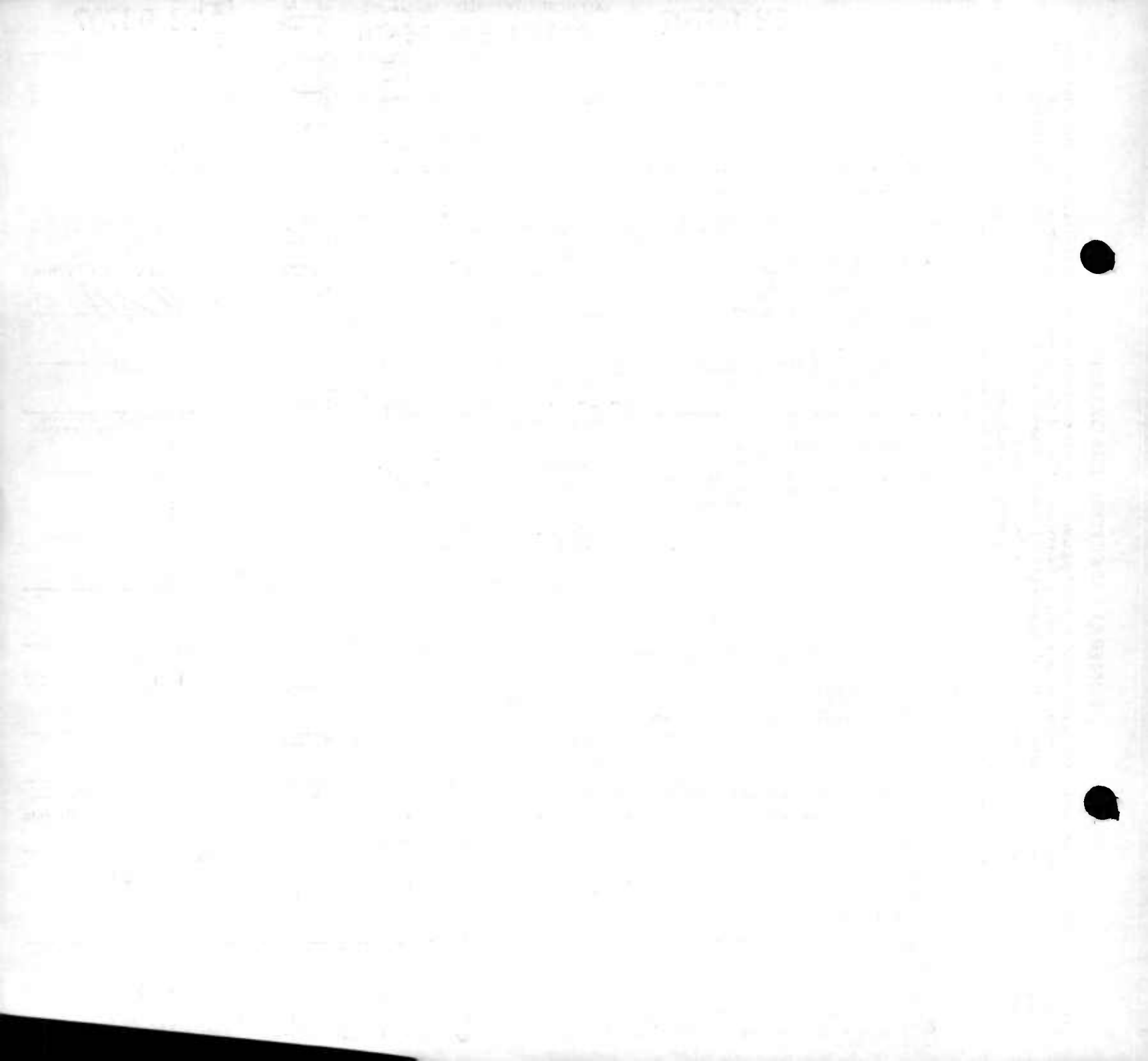
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 16-79-05	
BIRTH NO. <u>A-421</u>		72 03706		72 03706	
1. NAME OF DECEASED (Type or Print) <u>ALLSUP, FANNIE</u>			2. DATE AND HOUR OF DEATH <u>4/7/72</u> <u>425</u> <u>A.M.</u>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <u>38</u>		IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION <u>University Hospital</u> <u>Bald. Md.</u>		A. STATE <u>Maryland</u> B. COUNTY <u>1801</u>	
		C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER <u>914 W. Fayette</u>			
5. SEX <u>Female</u>	6. RACE <u>Black</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12/15/11</u>	9. AGE (In years last birthday) <u>60</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>unk.</u>			14. MOTHER'S MAIDEN NAME <u>unk.</u>		
15. Was Deceased Ever In U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>			16. SOCIAL SECURITY NO.		17. INFORMANT <u>admission Record</u> ADDRESS
18. <u>140.9</u> I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH			CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)			(A) IMMEDIATE CAUSE <u>Respiratory insuff</u>		<u>3 wks.</u>
ANTECEDENT CAUSES			(B) <u>Pulmonary metastasis</u>		<u>4 wks.</u>
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(C) <u>squamous cell CA-Lip.</u>		<u>14 months</u>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			<u>CA-transverse colon, CA-ovary.</u>		
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner) <u>never</u>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) <u>(this hospital)</u> attended the deceased from <u>3/5</u> 19 <u>72</u> to <u>4/7</u> 19 <u>72</u> that (I) <u>(we)</u> last saw the deceased alive on <u>4/7</u> 19 <u>72</u> and that in (my) <u>(our)</u> opinion death occurred on the date and hour and from the causes stated above. (I) <u>(We)</u> <u>(did)</u> <u>(did not)</u> view the body after death.					
23A. SIGNATURE <u>Frederic R. Eilber MD</u> DEGREE				23B. DATE SIGNED <u>4/7/72</u>	
23C. PHYSICIAN'S NAME (Type) <u>FRED R. EILBER MD</u> DEGREE				23D. ADDRESS <u>University Hospital</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>4-12-72</u>		24B. DATE <u>4-12-72</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Not Oakway Ck.</u>	
24D. LOCATION (City, town, or county) <u>Old County Md.</u>		24E. STATE <u>Md.</u>		24F. LOCATION (City, town, or county) <u>Old County Md.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>APR 18 1972</u>		25B. NAME OF REGISTRAR <u>Robert E. Fisher, R.D. 2</u>		25C. FUNERAL DIRECTOR <u>Edgar Johnson</u> ADDRESS <u>1075 Grantlyke</u>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>72 03707</u>	
BIRTH NO. <u>P-362</u>		72 03707		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <u>SOLOMON PATRICK</u>			2. DATE AND HOUR OF DEATH <u>4-15-72</u> <u>10:40AM.</u>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>THE JOHNS HOPKINS HOSPITAL</u> <u>BALTIMORE, MD 21205</u>			4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>843</u>		
5. SEX <u>MALE</u>			6. RACE <u>NEGRO</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <u>02-21-16</u>			9. AGE (In years last birthday) <u>56</u>		10. Under 1 Yr. Months: Days: Hours: Min.
11. BIRTHPLACE (State or foreign country) <u>Norfolk Va.</u>			12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
13. FATHER'S NAME <u>CHARLIE PATRICK</u>			14. MOTHER'S MAIDEN NAME <u>JOSEPHINE WEST</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>yes</u>			16. SOCIAL SECURITY NO. <u>417-03-0070</u>		17. INFORMANT <u>Virginia Patrick</u>
18. <u>185X</u> I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) IMMEDIATE CAUSE <u>Drops</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>Urinary obstruction & carcinoma</u> DUE TO, OR AS A CONSEQUENCE OF: (C) <u>Extensive carcinoma of the prostate</u>		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indefinitely medical examined) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>4/7</u> 19 <u>72</u> to <u>19</u> that (I) (we) last saw the deceased alive on <u>April 15</u> , 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>George E. Brannen M.D.</u>			23B. DATE SIGNED <u>4/15/72</u>		23C. PHYSICIAN'S NAME (Type)
24A. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			24B. DATE <u>4-20-72</u>		24C. NAME of CEMETERY or CREMATORY <u>Balto Cont</u>
24D. LOCATION (City, town, or county) <u>Balto Md</u>			(State)		
25A. DATE REC'D BY HEALTH DEPT. <u>APR 18 1972</u>		25B. NAME OF REGISTRAR <u>John E. Jones</u>		25C. FUNERAL DIRECTOR <u>George E. Brannen</u>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>72 03708</u>	
BIRTH NO. <u>J-552</u>		72 03708		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) Willie Jennings			2. DATE AND HOUR OF DEATH 4-17-72 5 A.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) The Good Samaritan Hospital 5601 Loch Raven Boulevard Baltimore, Maryland 21239			A. STATE Md. B. COUNTY Baltimore City 802		
5. SEX M 6. RACE B 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH 07-03-04 9. AGE (In years last birthday) 67		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer			11. BIRTHPLACE (State or foreign country) Unknown		
10B. KIND OF BUSINESS OR INDUSTRY			12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Unknown			14. MOTHER'S MAIDEN NAME Unknown		
15. Was Deceased Ever in U.S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Unknown			16. SOCIAL SECURITY NO. 250072389		
17. INFORMANT Mrs. Nora Jennings			ADDRESS Same		
18. CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) RESPIRATORY ARREST					
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. CANCER OF PANCREAS					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from March 21, 1972 to April 17, 1972 that (I) (we) last saw the deceased alive on April 17, 1972 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE William A. Carter, MD				23B. DATE SIGNED 4-17-72	
23C. PHYSICIAN'S NAME (Type) William A. Carter M.D.				23D. ADDRESS The Good Samaritan Hospital	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4-20-72		24C. NAME of CEMETERY or CREMATORY Mt Calvary Cent	
24D. LOCATION (City, town, or county) D.A. County		25A. DATE REC'D BY HEALTH DEPT. APR 18 1972		25B. NAME OF REGISTRAR Robert E. ...	
25C. FUNERAL DIRECTOR ...					



N-242

72 03709

BALTIMORE CITY HEALTH DEPARTMENT

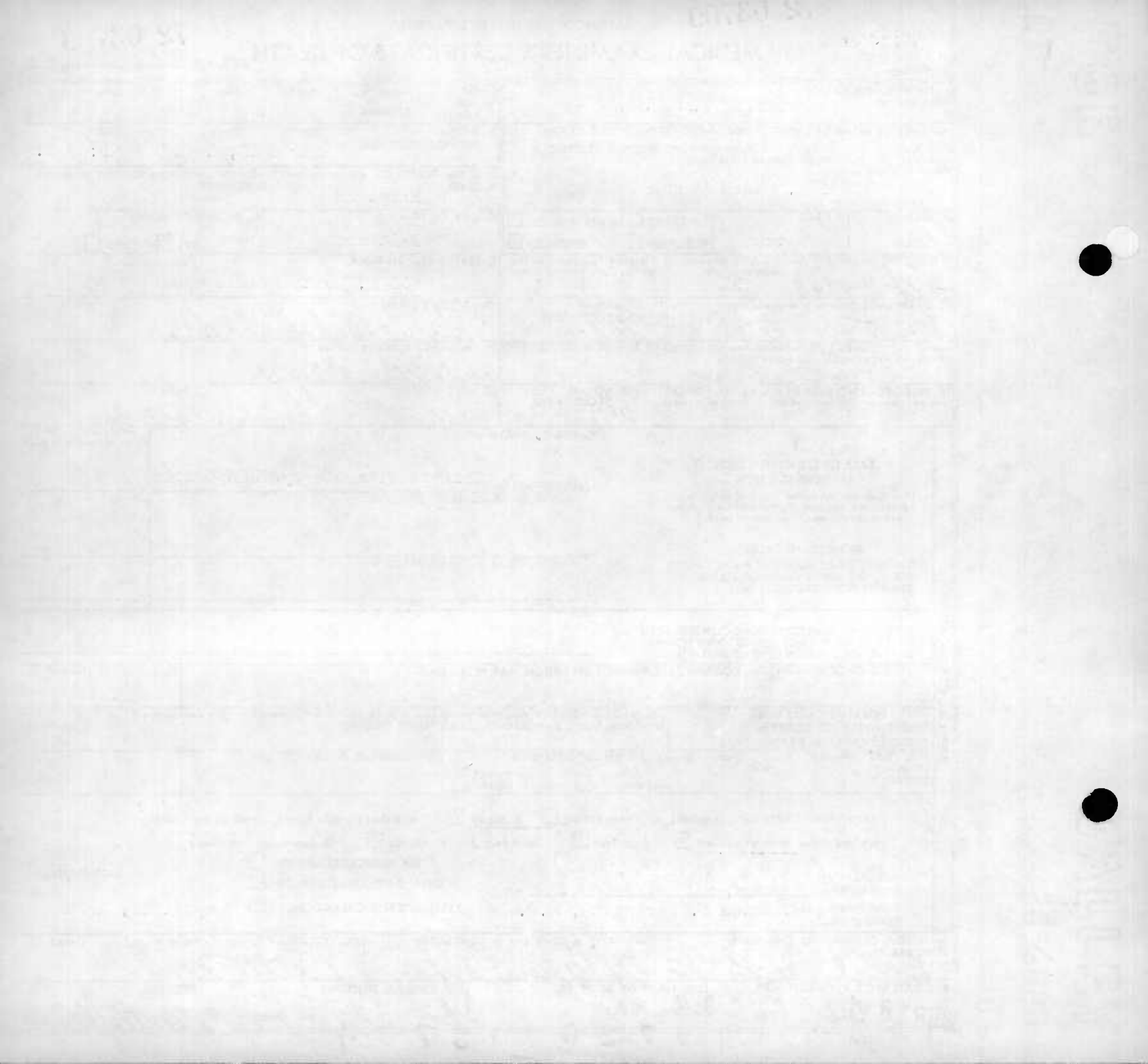
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

72 03709

BIRTH NO.

REG. NO.

1. NAME OF DECEASED (Type or Print) RUFUS NICHOLSON		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 00 433 E. North Avenue		3. DATE PRONOUNCED DEAD Month Day Year Hour April 13, 1972 3:05 A. M.	
5. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY 1205			
6. SEX Male	7. RACE Negro	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH Feb 11-1942		10. AGE (in years lost birthday) 30 If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) Baltimore Md		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Rufus Nicholson Sr		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Labr	
15. MOTHER'S MAIDEN NAME Isabelle Payne		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) 217-38-1009	
17. SOCIAL SECURITY NO. 217-38-1009		18. INFORMANT Isabelle Nicholson 1946 Howard Ave	
19. 590.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) (A) IMMEDIATE CAUSE Bilateral acute pyelonephritis DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) Yes			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?		22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Charles S. Springate M.D. EXAMINER'S NAME (Type) Charles S. Springate, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED April 13, 1972	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 4-13-72	24C. NAME OF CEMETERY or CREMATORY Mt Auburn Cem	24D. LOCATION (City, town, or county) (State) Baltimore Md
25A. DATE REC'D BY HEALTH DEPT. APR 18 1972	25B. NAME OF REGISTRAR Robert E. Fisher, M.D.	25C. FUNERAL DIRECTOR Edouard 1000 Bland St	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 03710	
W-600 72 03710		BIRTH NO. G-630		72 03710	
1. NAME OF DECEASED (Type or Print) <u>WARE, Estelle (Yordy)</u>		2. DATE AND HOUR OF DEATH <u>4/6/72</u> <u>7:35</u> A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>md.</u> B. COUNTY <u>1402</u>			
FULL NAME OF HOSPITAL OR INSTITUTION <u>George Washington Nurse Home</u> <u>607 Pennsylvania Ave</u>		C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER <u>1414 Blunt Street</u>					
5. SEX <u>Female</u>	6. RACE <u>Black</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> <u>Unknown</u> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5/15/85</u>	9. AGE (In years lost birthday) <u>86</u>	10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Unknown</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Unknown</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>					
13. FATHER'S NAME <u>Unknown Charles Holloway</u>		14. MOTHER'S MAREN NAME <u>Unknown Jane Lomon</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>214-56-6810</u>		17. INFORMANT <u>Chart</u> ADDRESS <u>607 Pennsylvania Ave</u>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxiation, etc. It means the disease, injury or complication which caused death.) <u>412.1</u> CAUSE OF DEATH <u>HYPERTENSIVE ARTERIO-SCLEROTIC CARDIAC DISEASE</u> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>1</u> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>YEARS</u>			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from <u>16 MARCH</u> 19 <u>72</u> to <u>6 APRIL</u> 19 <u>72</u> that (1) (we) last saw the deceased alive on <u>16 MARCH</u> 19 <u>72</u> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Richard R. Tyson, M.D.</u> DEGREE		Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <u>6 APR 72</u>	
23C. PHYSICIAN'S NAME (Type) <u>Dr. Richard R. Tyson, M.D.</u> DEGREE		23D. ADDRESS <u>936 West North Avenue</u> <u>Baltimore, Maryland 21217</u>			
24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE <u>4-10-72</u>	24C. NAME OF CEMETERY or CREMATORY <u>Mt Calvary Cmt</u>		24D. LOCATION (City, town, or county) (State) <u>All County Md</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>APR 18 1972</u>	25B. NAME OF REGISTRAR <u>Robert E. Taylor, M.D.</u>	25C. FUNERAL DIRECTOR <u>Richard R. Tyson, M.D.</u>		ADDRESS <u>936 West North Avenue</u>	

1414 R. BRUNT ST

NEW YORK 3801 1/2
1/2-1/2 1/2 1/2 1/2

1/2 1/2 1/2 1/2 1/2

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				72 03711		REG. NO.	
14-400		72 03711		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print)		HELEN LEE HOWELL		2. DATE AND HOUR OF DEATH		4/16/72 11:35 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE		B. COUNTY	
LUTHERAN HOSPITAL OF MARYLAND		46		4311, SPRINGDALE AVE.		BALTO. MD. 21207	
5. SEX		6. RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH	
F		N		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		12-29-17	
9. AGE (In years last birthday)		10. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
54		None		VIRGINIA		USA	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Robert Parham				Eva Mae Rogers			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT	
No						CHART	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				CAUSE OF DEATH			
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
ANTECEDENT CAUSES				(B) DUE TO, OR AS A CONSEQUENCE OF:			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(C) DUE TO, OR AS A CONSEQUENCE OF:			
II				Gastrointestinal bleeding, Diabetic			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
4/16/72		Bleeding and gangrene foot		No			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
(Month) (Day) (Year) (Hour)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					
22. I certify that (I) (this hospital) attended the deceased from 2/21/72 to 4/16/72 that (I) (we) last saw the deceased alive on 4/16/72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE				23B. DATE SIGNED			
m. O'neare				4/16/72			
23C. PHYSICIAN'S NAME (Typol)				23D. ADDRESS			
DEGREE				DEGREE			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial		4-19-72		Mt. Auburn Cem.		Balto. Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR.		25C. FUNERAL DIRECTOR		ADDRESS	
APR 18 1972		E. J. [unclear]		E. J. [unclear]		1000 [unclear] Ave.	

was 2000000000

For MacLeod

Robert Gordon
Hornby
No

Printed at the Press of the
University of Cambridge
1900

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 5-653		72 03712		BALTIMORE CITY HEALTH DEPARTMENT		72 03712	
NAME OF DECEASED EVERNEZZER DURANT				REG. NO.			
1. NAME OF DECEASED (Type or Print) Evernezzer Durant				2. DATE AND HOUR OF DEATH April 6, 1972 8:10 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION George Washington Nursing Home 607 Pennsylvania Ave				A. STATE MD B. COUNTY 1001			
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				C. CITY OR TOWN Balto. Md.		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER 1046 Eder Street							
5. SEX Male	6. RACE Black	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-5-95	9. AGE (In years last birthday) 76	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Labourer		10B. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) South Carolina		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Abraham Durant				14. MOTHER'S MAIDEN NAME			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 213-076957		17. INFORMANT Christ		ADDRESS 607 Penns. Ave	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) 412.41 Pneumonia & dehydration				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. ASC M Uremia							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from Feb 27 19 72 to April 6 19 72 that (I) (we) lost saw the deceased alive on April 6 19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE H. E. Bondy				23B. DATE SIGNED 6 April 1972			
23C. PHYSICIAN'S NAME (Type) H. E. Bondy				23D. ADDRESS 607 Pennsylvania Ave			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4-14-72		24C. NAME OF CEMETERY or CREMATORY Barton C.		24D. LOCATION (City, town, or county) (State) Barton South Carolina	
25A. DATE REC'D BY HEALTH DEPT. APR 18 1972		25B. NAME OF REGISTRAR John E. Taylor, M.D.		25C. FUNERAL DIRECTOR John E. Taylor		ADDRESS Balto. Md.	

1046 N. 5th St. St.

—A

1046

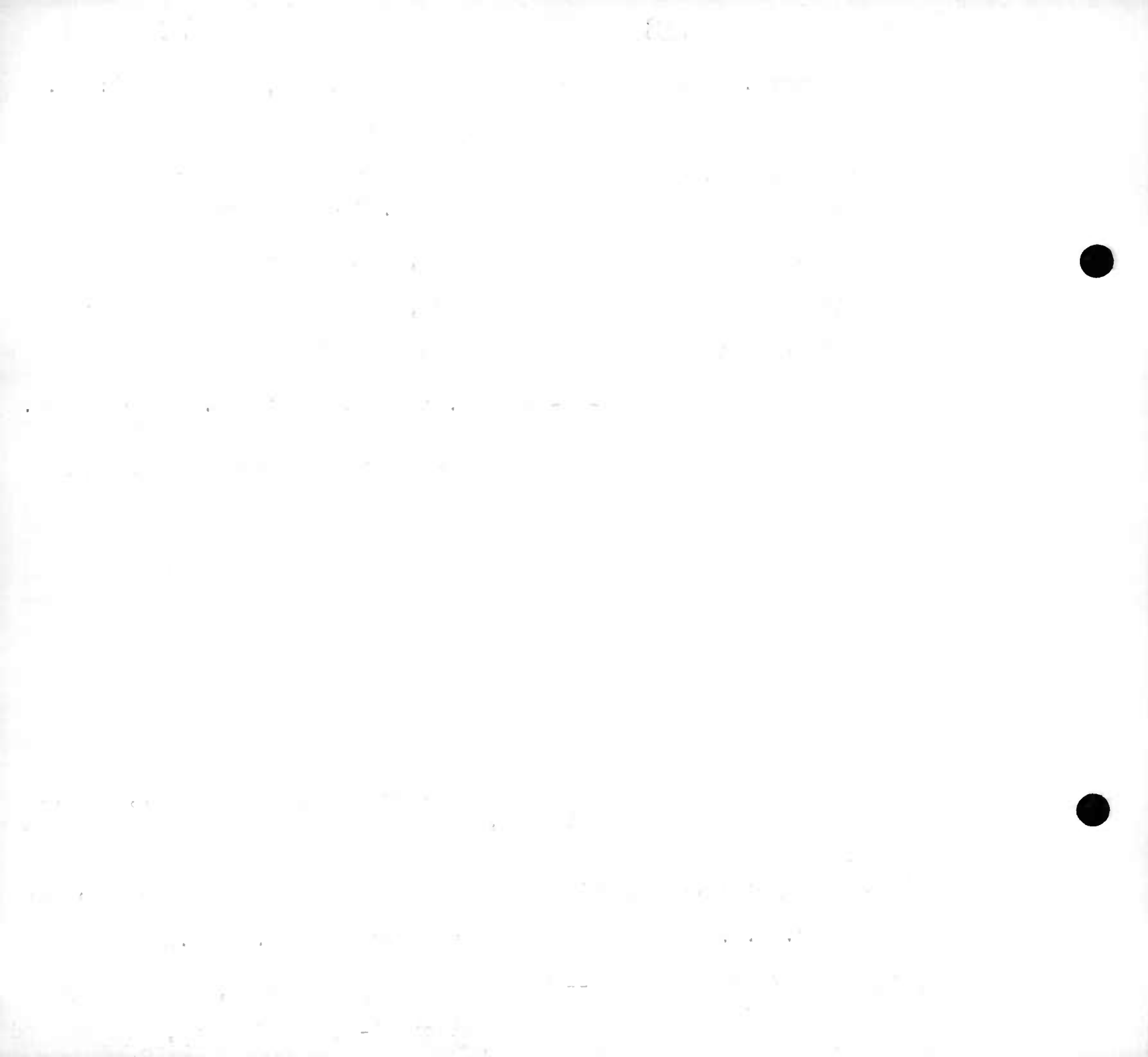
1046 N. 5th St. St.
1046 N. 5th St. St.
1046 N. 5th St. St.

1046 N. 5th St. St.
1046 N. 5th St. St.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

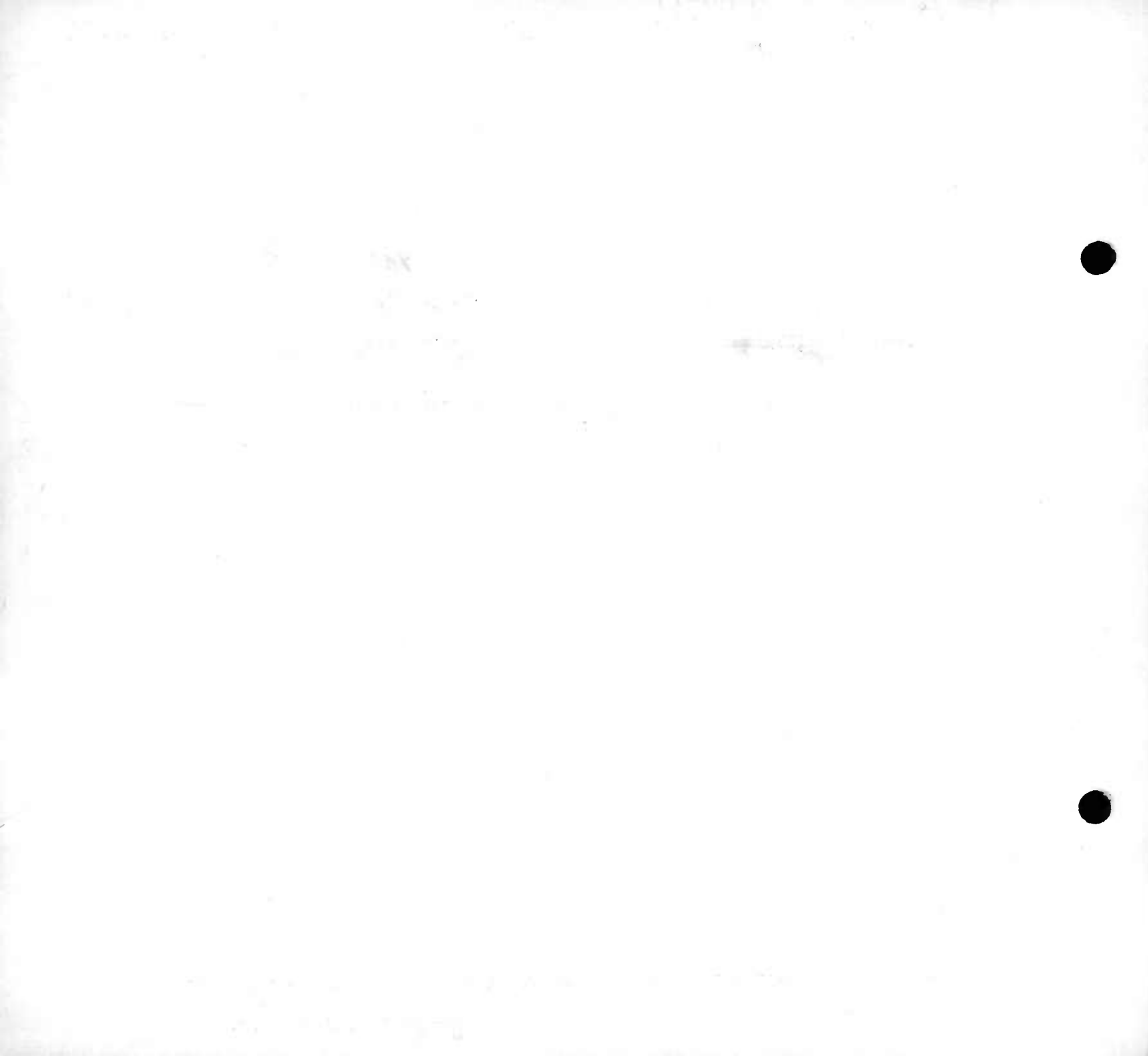
S-240		72 03713		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 03713	
BIRTH NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH			
Mrs. Pauline Sigle				April 17, 1972 5:50p. M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				A. STATE B. COUNTY			
00 1190 Northern Parkway Belvedere Towers				Maryland 2713			
5. SEX 6. RACE				7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
female white				8. DATE OF BIRTH 9. AGE (in years last birthday) 68			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY			
housewife				11. BIRTHPLACE (State or foreign country) 12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Vincent Wiesner				Anna Dreidenbach			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
no				218-68-7527			
17. INFORMANT				ADDRESS			
Mr. Alois Sigle				1190 W. Northern Pkwy.			
18. CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				6 months			
(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:				Metastatic carcinoma of the stomach			
(B) DUE TO, OR AS A CONSEQUENCE OF:							
(C) DUE TO, OR AS A CONSEQUENCE OF:							
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).							
20A. DATE OF OPERATION				20B. CONDITION FOR WHICH OPERATION WAS PERFORMED			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)							
21D. TIME OF INJURY (APPROX.)				21E. INJURY OCCURRED			
21F. HOW DID INJURY OCCUR?							
22. I certify that (I) (the deceased) attended the deceased from October 1971 to April 17, 1972 that (I) (we) last saw the deceased alive on April 17, 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (do not) view the body after death.							
23A. SIGNATURE				23B. DATE SIGNED			
Dr. W.E. Baermann				April 18, 1972			
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
Dr. W.E. Baermann				3401 Dundalk Ave. Balto. 21222			
24A. BURIAL CREMATION, REMOVAL (Specify)				24B. DATE			
burial				4/25/72			
24C. NAME OF CEMETERY OR CREMATORY				24D. LOCATION (City, town, or county) (State)			
--				Loehr am Main, Germany			
25A. DATE REC'D BY HEALTH DEPT.				25B. NAME OF REGISTRAR			
APR 18 1972				Mitchell-Wiedefeld Home, 6500 York Rd			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

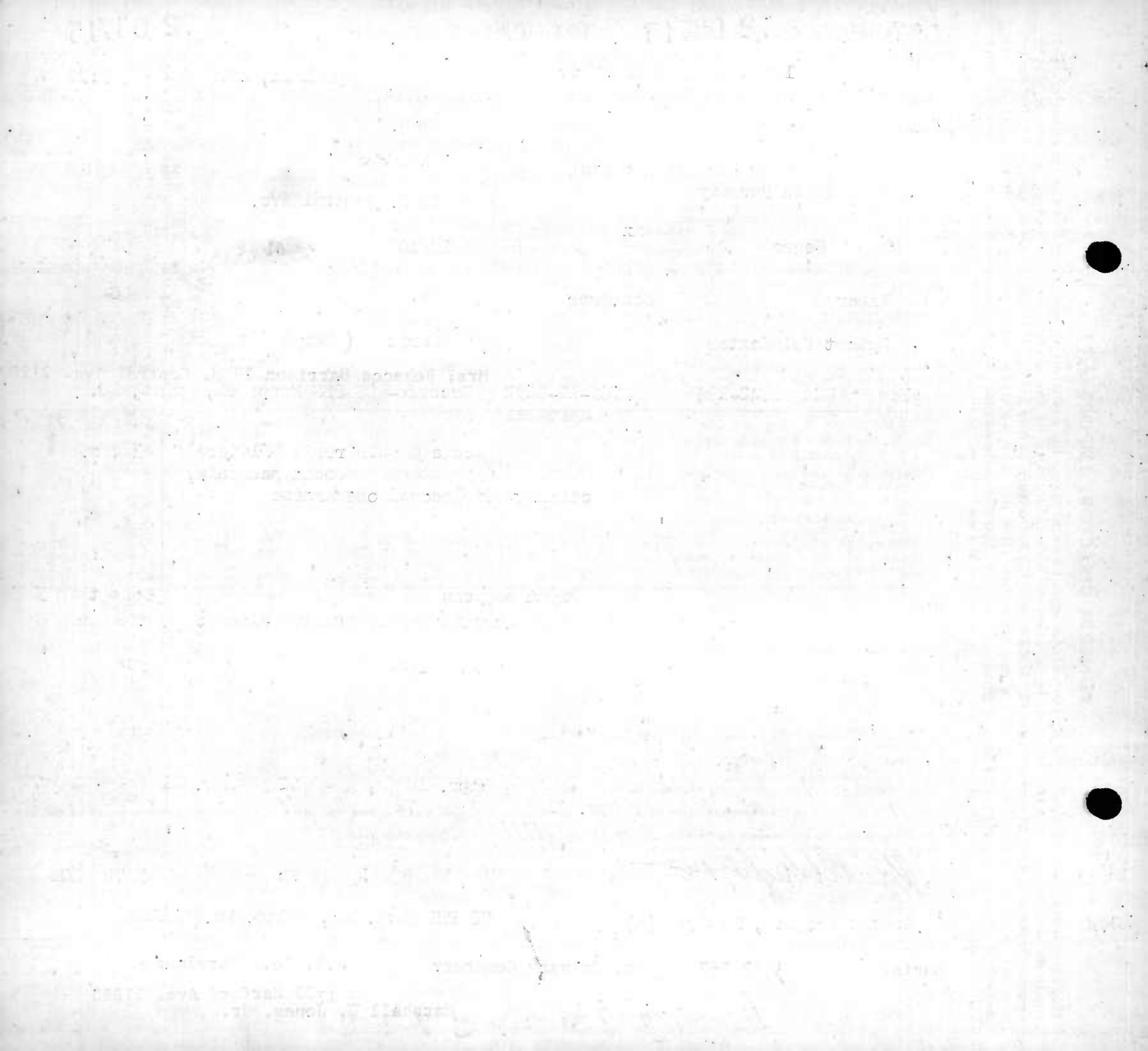
F-512		72 03714		BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		REG. NO. 72 03714						
1. NAME OF DECEASED (Type or Print) EMPSON, EVELYN					2. DATE AND HOUR OF DEATH 4/14/72 1:10 P.M.									
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Church Home & Hospital Baltimore, Md 21231					4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE md. B. COUNTY 665									
5. SEX F 6. RACE B 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>					8. DATE OF BIRTH 3/20/95		9. AGE (in years last birthday) 77		10. Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.					
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife					10B. KIND OF BUSINESS OR INDUSTRY —			11. BIRTHPLACE (State or foreign country) Dorchester, Maryland		12. CITIZEN OF WHAT COUNTRY? USA				
13. FATHER'S NAME Benjamin Tillighman					14. MOTHER'S MAIDEN NAME Rosie Kane									
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO					16. SOCIAL SECURITY NO. —		17. INFORMANT Mr. John Empson 1608 May Court				ADDRESS			
18. 436.91 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Cerebrovascular Accident recent					(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Arteriosclerosis					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH years				
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. —					(B) DUE TO, OR AS A CONSEQUENCE OF: —					(C) —				
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). —														
19A. DATE OF OPERATION 0				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED —				20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)						
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) —				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				21F. HOW DID INJURY OCCUR? —						
22. I certify that (I) (this hospital) attended the deceased from — 19 — to — 19 — that (I) (we) last saw the deceased alive on — 19 — and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.														
23A. SIGNATURE Dr. Gongor, M.D.								23B. DATE SIGNED 4-14-72		23C. PHYSICIAN'S NAME (Type) MANUEL GONGON				
23D. ADDRESS Church Home & Hospital				23E. DEGREE —										
24A. BURIAL CREMATION, REMOVAL (Specify) Burial				24B. DATE 4-17-1972		24C. NAME OF CEMETERY or CREMATORY Holy Redemer Cemetery				24D. LOCATION (City, town, or county) (State) Baltimore, Maryland				
25A. DATE REC'D BY HEALTH DEPT. APR 18 1972				25B. NAME OF REGISTRAR Robert E. Jones, Jr.				25C. FUNERAL DIRECTOR 735 Harford Ave. 21213 Marshall W. Jones, Jr.						



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 03715	
P-532 72 03715		CERTIFICATE OF DEATH			
BIRTH NO.		1. NAME OF DECEASED (Type or Print) Elbert Brown Poindexter		2. DATE AND HOUR OF DEATH April 11, 1972 3:35 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) US Public Health Service Hospital 2X 3100 Wyman Parkway		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY 302		C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX M 6. RACE Negro		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 5/10/10 9. AGE (In years lost birthday) 61	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Wiper		10B. KIND OF BUSINESS OR INDUSTRY Seafarer		11. BIRTHPLACE (State or foreign country) Va. 12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Robert Poindexter		14. MOTHER'S MAIDEN NAME Marie (Mary) ?			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) Yes USA 1942-1945		16. SOCIAL SECURITY NO. 705-12-0252		17. INFORMANT Mrs. Rebecca Harrison 29 N. Central Ave. 21202 Records- US PHS Hospital, Balto, Md.	
18. 481X1 CAUSE OF DEATH		DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) Acute & subchronic bilateral bronchopneumonia, etiology diplococci pneumoniae		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 wks.	
19. MEDICAL CERTIFICATION		20. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.		21. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). Right empyema Atherosclerotic cardiovascular disease	
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Apr. 10 19 72 to Apr. 11 19 72, that (I) (we) last saw the deceased alive on Apr. 11 19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Robert Wright, M.D.		23B. DATE SIGNED 4/13/72 RGB		23C. PHYSICIAN'S NAME (Type) Robert Wright, SA Surg.-(R)	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4-17-1972		24C. NAME OF CEMETERY OR CREMATORY Mt. Calvary Cemetery	
25A. DATE REC'D BY HEALTH DEPT. APR 18 1972		25B. NAME OF REGISTRAR Robert E. Jones, Jr.		25C. FUNERAL DIRECTOR 1735 Harford Ave. 21215 Marshall W. Jones, Jr.	
24D. LOCATION (City, town, or county) A.A. Co., Maryland		24E. LOCATION (State) (State)			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>72 03716</u>	
BIRTH NO. <u>C-462</u>		72 03716		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <u>MARGARET G CLARK</u>			2. DATE AND HOUR OF DEATH <u>4-16-72</u> <u>7:26 A.M.</u>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>BALTO.</u>		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>PROVIDENT HOSPITAL</u> <u>LIBERTY HTS. AVE.</u> <u>4-19-72</u>			CITY OR TOWN <u>BALTO.</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
5. SEX <u>F</u>			6. RACE <u>B</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-29-20</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>			10B. KIND OF BUSINESS OR INDUSTRY		9. AGE (In years last birthday) <u>51</u>
11. BIRTHPLACE (State or foreign country) <u>Talbot Co, Maryland</u>			12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>		
13. FATHER'S NAME <u>William A. Goldsborough</u>			14. MOTHER'S MAIDEN NAME <u>Susie Seth</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u>			16. SOCIAL SECURITY NO. <u>218-30-6320</u>		17. INFORMANT <u>MR. HENDERSON CLARK</u> <u>2445 McCulloh St. 21217</u> ADDRESS
18. <u>410.9</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>MYOCARDIAL INFARCT</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>6 HRS.</u>		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>NO</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>4-16-1972</u> to <u>4-16-1972</u> that (I) (we) last saw the deceased alive on <u>4-16-1972</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Jaime F. Casellas M.D.</u>			23B. DATE SIGNED <u>4-16-72</u>		23C. PHYSICIAN'S NAME (Type) <u>JAIME F. CASELLAS M.D.</u>
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>			24B. DATE <u>4-20-1972</u>		24C. NAME of CEMETERY or CREMATORY <u>Arbutus Memorial Park</u>
25A. DATE REC'D BY HEALTH DEPT. <u>APR 18 1972</u>			25B. NAME OF REGISTRAR <u>Marshall W. Jones, Jr.</u>		25C. FUNERAL DIRECTOR <u>1735 Harford Ave. 21215</u>

4-19-1972 - Letter from Provident Hospital, Inc. Phyllis Brown -RRL

&

Certification by Funeral Director - Marshall W. Jones, Jr.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

J-230		72 03717		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 03717	
BIRTH NO.				1. NAME OF DECEASED (Type or Print) ANTHONY F. JUST			
2. DATE AND HOUR OF DEATH 4-17-72 10:55 P.M.				3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD Church Home and Hospital 100 N Broadway St. Baltimore MD 21231			
4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MD. B. COUNTY 105				5. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
6. STREET AND NUMBER 243 S. Madeira St. 21231				7. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Church Home and Hospital 100 N Broadway St. Baltimore MD 21231			
8. SEX Male		9. RACE White		10. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		11. DATE OF BIRTH 5-7-1906	
12. AGE (In years last birthday) 65		13. If Under 1 Yr. Months: Days: Hours: Min.		14. BIRTHPLACE (State or foreign country) Poland		15. CITIZEN OF WHAT COUNTRY? U.S.A.	
16. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unknown				17. KIND OF BUSINESS OR INDUSTRY Unknown			
18. FATHER'S NAME ALEXANDER JUST				19. MOTHER'S MAIDEN NAME HELEN			
20. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				21. SOCIAL SECURITY NO. 215010786		22. INFORMANT A. Fouad Nour M.D.	
23. ADDRESS Church Home and Hospital				24. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 20 minutes			
25. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Acute Myocardial Infarction				26. IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: AS-CV-D - CHF			
27. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Mild Diabetes Mellitus				28. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
29. DATE OF OPERATION None		30. CONDITION FOR WHICH OPERATION WAS PERFORMED None		31. AUTOPSY? (Yes or No) None		32. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
33. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) None		34. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) None		35. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) None		36. HOW DID INJURY OCCUR? None	
37. TIME OF INJURY (Month) (Day) (Year) (Hour) None		38. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		39. I certify that (I) (this hospital) attended the deceased from 4-3-72 19 to 4-17 1972 that (I) (we) last saw the deceased alive on 4-17 1972 and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
40. SIGNATURE A. Fouad Nour				41. DATE SIGNED 4-17-72		42. PHYSICIAN'S NAME (Type) A. Fouad Nour	
43. ADDRESS Church Home and Hospital 100 N Broadway St. Baltimore MD 21231		44. NAME OF CEMETERY OR CREMATORY St. Stanislaus Cemetery		45. LOCATION (City, town, or county) (State) 6515 Boston St, Baltimore, Md.		46. DATE REC'D BY HEALTH DEPT. APR 18 1972	
47. NAME OF REGISTRAR Robert E. Taylor		48. FUNERAL DIRECTOR Lilly & Geller Inc		49. ADDRESS 1901 Eastern Ave, Baltimore, Md.		50. VS 150-REV. 1/1/68	



I-515

72 03718 BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

72 03718

BIRTH NO.

REG. NO.

1. NAME OF DECEASED (Type or Print) LILA INABINETTE		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) LUTHERAN HOSPITAL		3. DATE PRONOUNCED DEAD Month Day Year Hour April 15, 1972 8:40 P.	
6. SEX Female		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
7. RACE Negro		C. CITY OR TOWN Baltimore	
9. DATE OF BIRTH 4-2-1921		10. AGE (In years, months, days, hours, minutes) 51	
11. BIRTHPLACE (State or foreign country) SC		12. CITIZEN OF WHAT COUNTRY? US	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		14B. KIND OF BUSINESS OR INDUSTRY	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) NO		17. SOCIAL SECURITY NO.	
15. MOTHER'S MAIDEN NAME Bertha Ralph		18. INFORMANT ADDRESS	
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) E8801X		CAUSE OF DEATH Craniocerebral Injuries	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		(B) DUE TO, OR AS A CONSEQUENCE OF:	
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) yes		22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	
22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Home		22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 918 Poplar Grove Street	
22D. TIME (Month) (Day) (Year) (Hour) (Approx.) 4-15-72		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	
22F. HOW DID INJURY OCCUR? fell down steps		23.	
I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Ronald N. Kornblum, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
DATE SIGNED 4/17/72		24A. BURIAL CREMATION, REMOVAL (Specify) Burial	
24B. DATE 4-20-72		24C. NAME OF CEMETERY or CREMATORY West Auburn	
24D. LOCATION (City, town, or county) (State) Baltimore, Md.		25A. DATE REC'D BY HEALTH DEPT. APR 18 1972	
25B. NAME OF REGISTRAR Ronald N. Kornblum, M.D.		25C. FUNERAL DIRECTOR C. E. Wright	
25D. ADDRESS 2700 Edmondson		VS 151-REV. 7/1/68	

Chad Miller

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

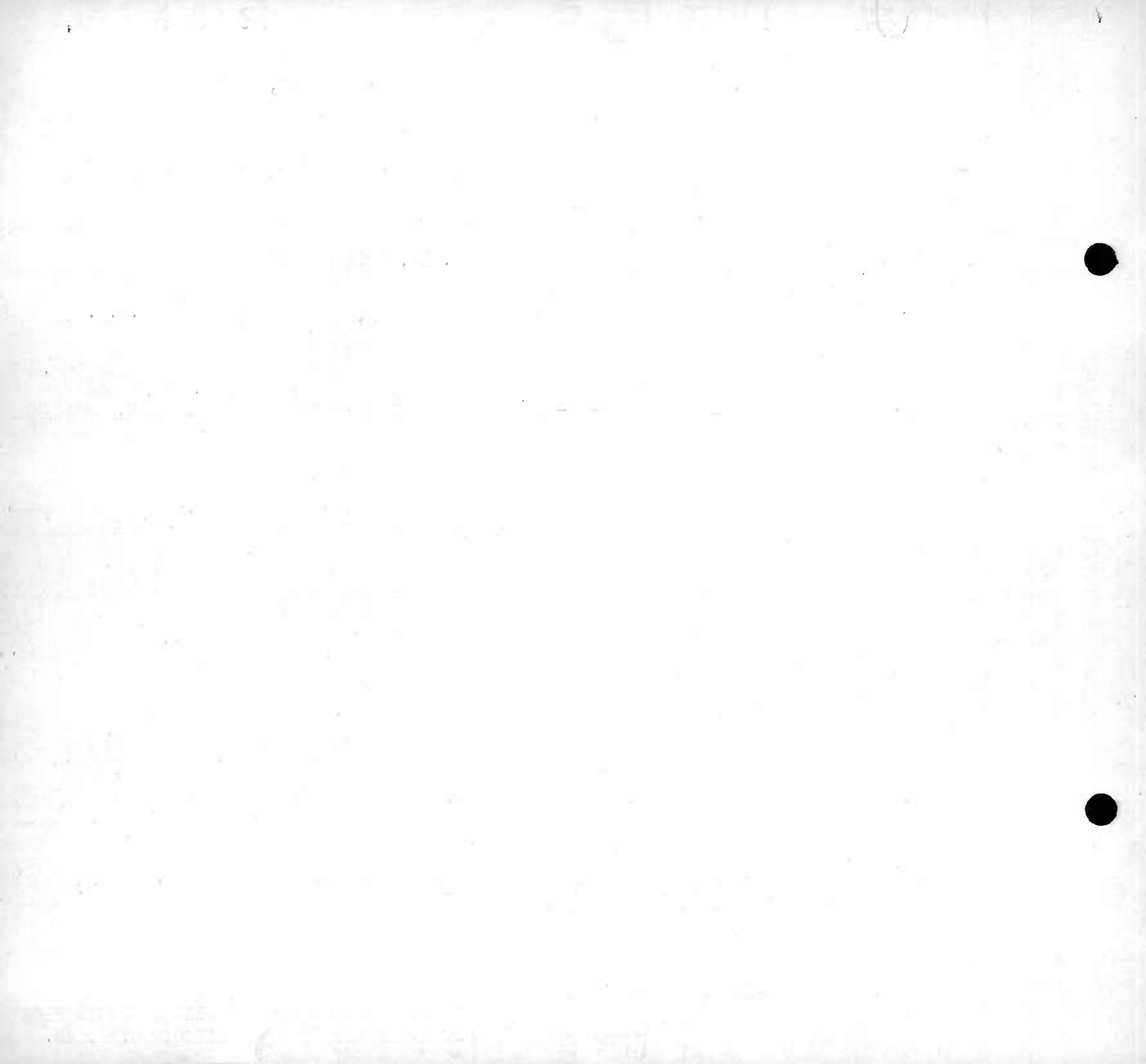
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 03719	
1-200				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) Mary Louise Lewis			2. DATE AND HOUR OF DEATH April 16, 1972		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 40 St. Agnes Hospital			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY 2582		
			C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER 3129 Wilkens Avenue 21223		
5. SEX Female	6. RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 9/14/07	9. AGE (In years lost birthday) 64	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) West Virginia	
13. FATHER'S NAME Davis			14. MOTHER'S MAIDEN NAME Frances		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO. 217-07-4849		
			17. INFORMANT Horace E. Lewis		
			ADDRESS 3129 Wilkens Avenue 21223		
18. 410.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ASHD ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Crown Thrombosis		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1/2 hour 2 years
			(B) DUE TO, OR AS A CONSEQUENCE OF:		
			(C) DUE TO, OR AS A CONSEQUENCE OF:		
MEDICAL CERTIFICATION					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from January 1, 1950 to April 17, 1972 , that (I) (we) last saw the deceased alive on April 8, 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Morris W. Steinberg			23B. DATE SIGNED 4/18/72		
23C. PHYSICIAN'S NAME (Type) Morris W. Steinberg			23D. ADDRESS 3913 Hollins Ferry Rd.		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4/20/72		24C. NAME of CEMETERY or CREMATORY New Cathedral	
				24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. APR 18 1972		25B. NAME OF REGISTRAR Robert E. Fisher, M.D.		25C. FUNERAL DIRECTOR Witzke	
				ADDRESS 1630 Edmondson Avenue 21228	

21.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. 72 03720	
1. NAME OF DECEASED (Type or Print) PAUL E. TICE			2. DATE AND HOUR OF DEATH APRIL 16, 1972		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 664 BRISBANE ROAD BALTIMORE, MARYLAND 21229			4. USUAL RESIDENCE (Where deceased lived, If institution; residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 664 BRISBANE ROAD		
5. SEX MALE	6. RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH OCT. 18, 1896	9. AGE (In years last birthday) 75	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CLERK			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) BALTIMORE, MARYLAND
12. CITIZEN OF WHAT COUNTRY? U.S.A.			13. FATHER'S NAME UNKNOWN		
14. MOTHER'S MAIDEN NAME UNKNOWN			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES WORLD WAR 1		
16. SOCIAL SECURITY NO. 214-03-2654			17. INFORMANT (MRS) ORVAL SMOOT		
18. CAUSE OF DEATH 410.91 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 19A. DATE OF OPERATION 4/10/72 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 20A. AUTOPSY? (Yes or No) 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> 21F. HOW DID INJURY OCCUR? 22. I certify that (I) (this hospital) attended the deceased from 3/28/72 19 to 4/16/72 19, that (I) (we) last saw the deceased alive on 3/24/72 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. 23A. SIGNATURE Kennard Yaffe M.D. 23B. DATE SIGNED 4/17/72 23C. PHYSICIAN'S NAME (Type) KENNARD YAFFE M.D. 23D. ADDRESS 5501 FOREST PARK BALTO. MD. 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL 24B. DATE 04/19/72 24C. NAME OF CEMETERY or CREMATORY GETTYSBURG NAT'L CEMETERY 24D. LOCATION (City, town, or county) (State) GETTYSBURG, PENNSYLVANIA 25A. DATE REC'D BY HEALTH DEPT. APR 18 1972 25B. NAME OF REGISTRAR Robert E. [unclear] 25C. FUNERAL DIRECTOR HOWARD COUNTY FUNERAL of HARRY WITZKE ADDRESS 4112 COLUMBIA PIKE ELLICOTT CITY, MD.					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT 72 03721 CERTIFICATE OF DEATH									
BIRTH NO. R-320		1. NAME OF DECEASED (Type or Print) Frederick Reitz		2. DATE AND HOUR OF DEATH 4/14/72 11:15 P.M.		REG. NO. 72 03721			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 38 University Hospital Green Street (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Ma B. COUNTY Howard C. CITY OR TOWN Ellicott City D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER Columbia Pike					
5. SEX male		6. RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9/10/06		9. AGE (In years lost birthday) 65	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Proprietor				10B. KIND OF BUSINESS OR INDUSTRY Florist Business		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Late Frederick Reitz				14. MOTHER'S MAIDEN NAME Late Helena					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no				16. SOCIAL SECURITY NO. 215-22-1185		17. INFORMANT ADDRESS Mrs. Pauline Reitz, Columbia Pike, 21043			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) 412.31 Coronary Insufficiency				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Coronary Insufficiency				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 yrs +	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) Arteriosclerotic H.D. DUE TO, OR AS A CONSEQUENCE OF:					
(C) _____									
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). II									
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR?		(If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from 8/10 19 67 to 4/14 19 72 , that (I) (we) last saw the deceased alive on 2/29 19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE C. Edward Leach, M.D.				Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 4/15/72			
23C. PHYSICIAN'S NAME (Type) Dr. C. Edward Leach				23D. ADDRESS 14 E. Eager Street					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4/18/72		24C. NAME of CEMETERY or CREMATORY Lorraine Park Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland			
25A. DATE REC'D BY HEALTH DEPT. APR 18 1972		25B. NAME OF REGISTRAR John E. Witzke		25C. FUNERAL DIRECTOR ADDRESS Witzke, 1630 Edmondson Avenue 21228					

VS 151-REV. 7/1/68

SS 10 5

SS 10 5

RECEIVED THE 10th OF 10 1955

10 10 1955

10 10 1955

10 10 1955

10 10 1955

10 10 1955

10 10 1955

10 10 1955

ACADEMY OF BOWLING

WALLACE

10 10 1955

10 10 1955

10 10 1955

10 10 1955

10 10 1955

10 10 1955

10 10 1955

10 10 1955

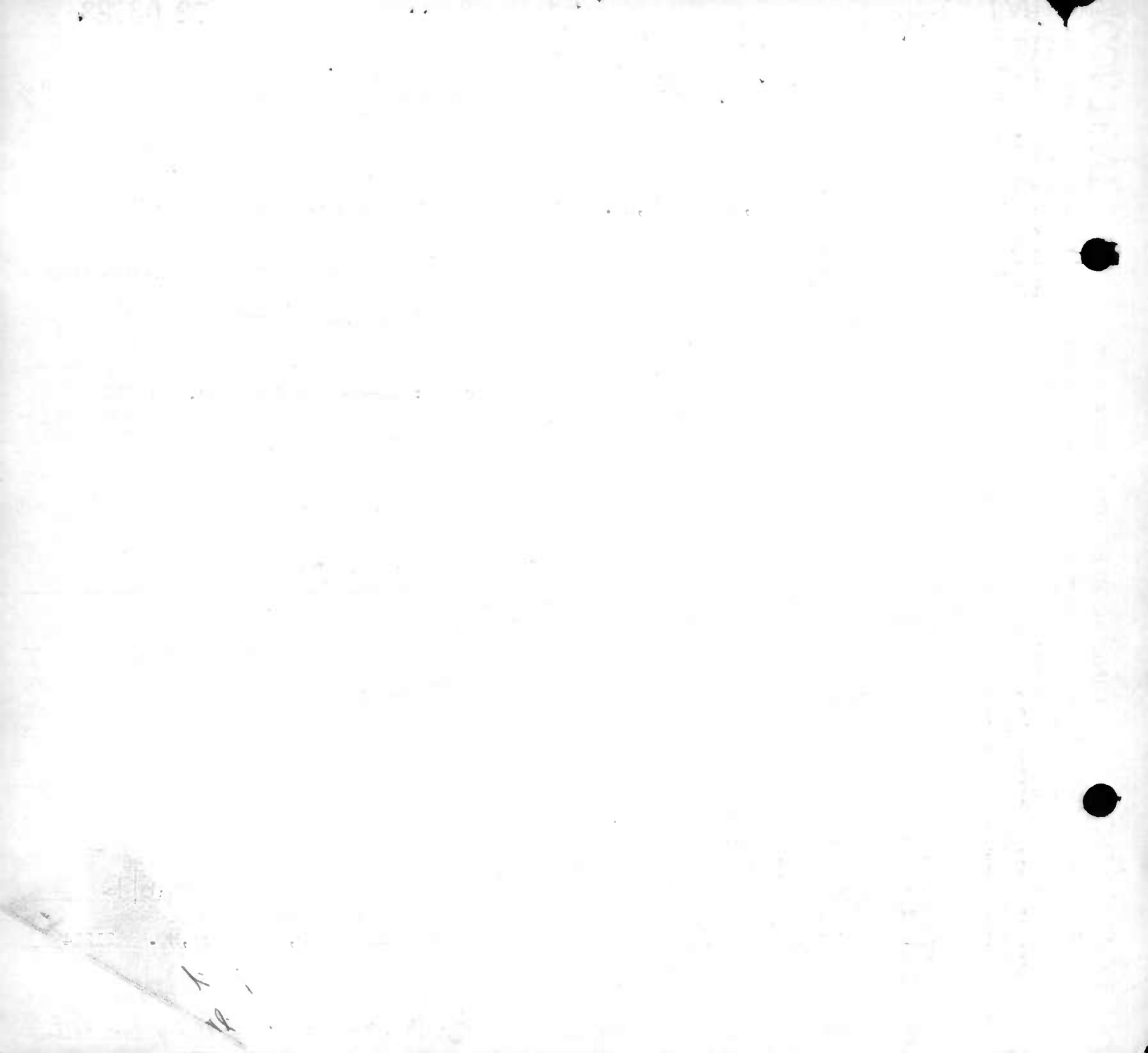
10 10 1955

10 10 1955

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

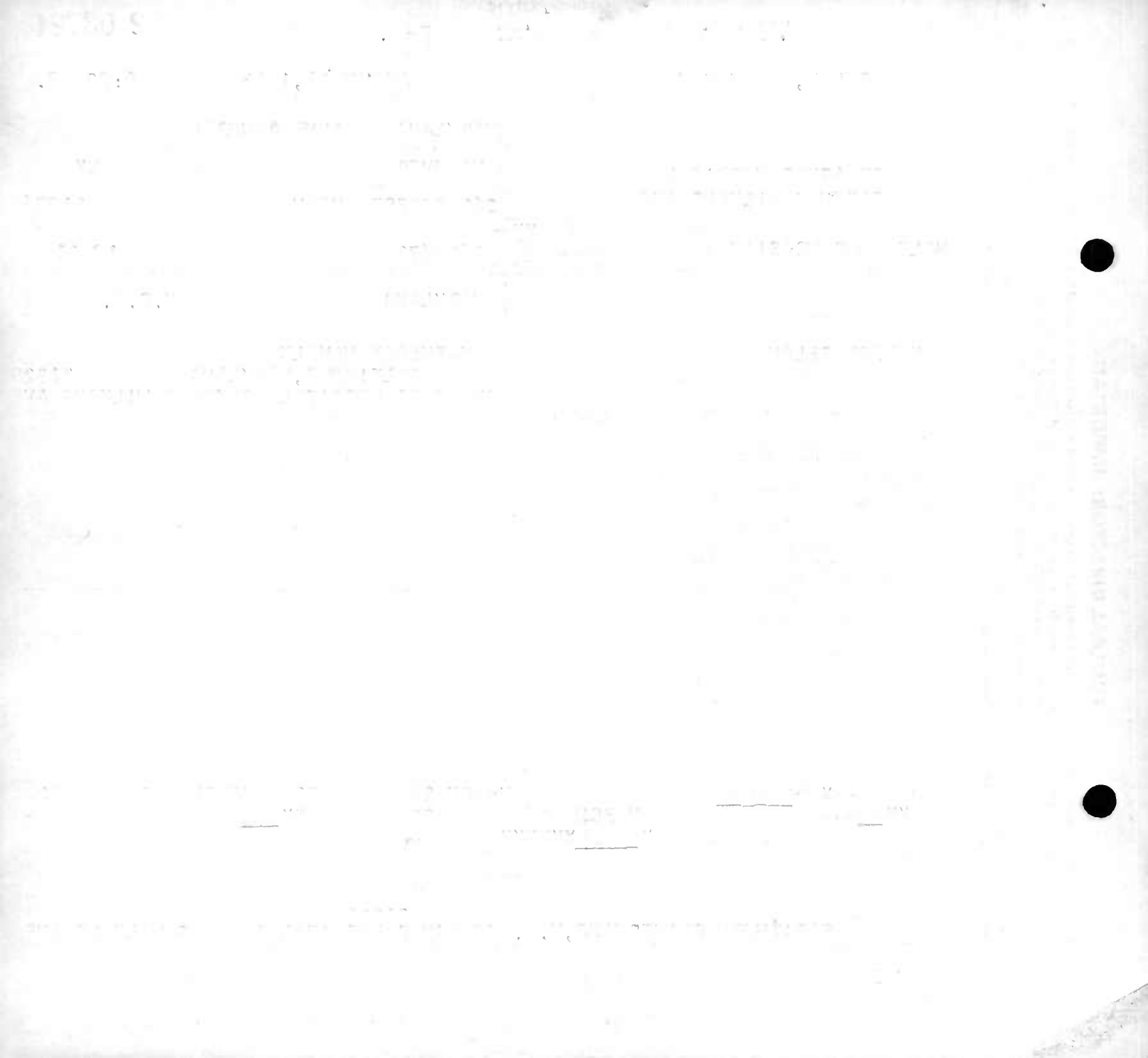
K-660		72 03723		BALTIMORE CITY HEALTH DEPARTMENT		72 03723	
BIRTH NO.		72 03723				REG. NO.	
1. NAME OF DECEASED (Type or Print)				MARIE E. KERHER		2. DATE AND HOUR OF DEATH APRIL 16, 1972 7:00 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE MD		B. COUNTY 2609	
31 Baltimore City Hospitals		4940 Eastern Avenue, Baltimore, Md. 21224		C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER 1018 S BAYLISS STREET							
5. SEX Female	6. RACE Caucasian	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/24/06	9. AGE (In years last birthday) 66	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) PENNSYLVANIA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME George Dans				14. MOTHER'S MAIDEN NAME EDITH.			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 212-01-0991		17. INFORMANT Records: BCH-4940 Eastern Ave.		ADDRESS 21224	
18. 203X1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH CARDIORESPIRATORY ARREST (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: FEVER OF UNKNOWN ETIOLOGY (B) DUE TO, OR AS A CONSEQUENCE OF: (C) MULTIPLE MYELOMA II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). CACHEXIA, ANEMIA, pulmonary infiltrates, and undetermined etiology				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 3/17/72 to 4/16/72 that (I) (we) last saw the deceased alive on 4/16/72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Richard R. Love MD				23B. DATE SIGNED 4/16/72			
23C. PHYSICIAN'S NAME (Type) RICHARD REED LOVE MD				23D. ADDRESS Baltimore City Hospitals 4940 Eastern Avenue, Baltimore, Md. 21224			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4/19/72		24C. NAME OF CEMETERY OR CREMATORY BALTO NATIONAL		24D. LOCATION (City, town, or county) (State) BALTO. MD	
25A. DATE REC'D BY HEALTH DEPT. APR 18 1972		25B. NAME OF REGISTRAR Ruth E. Johnson		25C. FUNERAL DIRECTOR Ruth E. Johnson		ADDRESS 1630 Edmondson Ave	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 03724	
BIRTH NO. 1. NAME OF DECEASED (Type or Print) SELPH, BABY BOY		2. DATE AND HOUR OF DEATH MARCH 28, 1972 6:00 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 40 ST AGNES HOSPITAL CATON & WILKENS AVE		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY ANNE ARUNDEL 5200 C. CITY OR TOWN HANOVER D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER 262 FOREST AVENUE 21076			
5. SEX MALE	6. RACE CAUCASIAN	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/28/72	9. AGE (In years last birthday) 10 31	If Under 1 Yr. Months Days Hours Min. 10 31
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME KEMPER SELPH			
14. MOTHER'S MAIDEN NAME KATHLEEN HAVELKA		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO.		17. INFORMANT BALTIMORE, MARYLAND ADDRESS 21229 ST AGNES HOSPITAL CATON & WILKENS AVE			
18. CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) IMMEDIATE CAUSE <i>Erythroblastosis</i> DUE TO, OR AS A CONSEQUENCE OF: (B) <i>Patent Conus arteriosus & Foramen ovale</i> DUE TO, OR AS A CONSEQUENCE OF: (C) <i>Atelectasis of lungs</i>		
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>9 hrs</i>			II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		
19A. DATE OF OPERATION 3/28/72		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Exchanged Transfusion</i>		20A. AUTOPSY (Yes or No) <i>Yes</i>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		(If in Baltimore City, give exact location)			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR?	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (X) (this hospital) attended the deceased from MARCH 28 19 72 to MARCH 28 19 72 that (XX) (we) last saw the deceased alive on MARCH 28 19 72 and that in (XX) (our) opinion death occurred on the date and hour end from the causes stated above. (X) (We) (did) XXXXXX view the body after death.					
23A. SIGNATURE <i>Sasithorn Chittchang</i>				23B. DATE SIGNED 3/28/72	
23C. PHYSICIAN'S NAME (Type) SASITHORN CHITTCHANG, M.D.				23D. ADDRESS 21229 ST AGNES HOSPITAL CATON & WILKENS AVE	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4/17/72		24C. NAME OF CEMETERY OR CREMATORY New Cathedral	
24D. LOCATION (City, town, or county) (State) Baltimore, Maryland		25A. DATE RECEIVED BY HEALTH DEPT. APR 18 1972 25B. NAME OF REGISTRAR Witzke 25C. FUNERAL DIRECTOR 1630 Edmondson Aven 21228			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <u>C-200</u> <u>72 03725</u>				BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		REG. NO. <u>72 03725</u>	
1. NAME OF DECEASED (Type or Print) <u>COX, BABY GIRL</u>				2. DATE AND HOUR OF DEATH <u>APRIL 16, 1972</u> <u>2:15 A.M.</u>					
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <u>ST AGNES HOSPITAL</u> <u>CATON & WILKENS AVENUES</u> <u>BALTIMORE, MARYLAND 21229</u>				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>21223</u> <u>1902</u> C. CITY OR TOWN <u>BALTIMORE</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>205 S. CALHOUN STREET</u>					
5. SEX <u>FEMALE</u>		6. RACE <u>CAUCASIAN</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>04/14/72</u>		9. AGE (In years last birthday) <u>1</u> <u>16</u> <u>15</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>INFANT</u>				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>ROGER COX</u>				14. MOTHER'S MAIDEN NAME <u>MARY ELLEN LINGENMYER REMMERT</u>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>				16. SOCIAL SECURITY NO.		17. INFORMANT <u>BALTO MD 21229</u> ADDRESS <u>ST AGNES' RECORDS CATON & WILKENS AVES</u>			
18. <u>776.21</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>Respiratory distress syndrome</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>Pneumonia</u> DUE TO, OR AS A CONSEQUENCE OF: (C) _____				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19. DATE OF OPERATION <u>0</u>				19A. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that <u>(X)</u> (this hospital) attended the deceased from <u>APRIL 15</u> 19 <u>72</u> to <u>APRIL 16</u> 19 <u>72</u> that <u>(X)</u> (we) last saw the deceased alive on <u>APRIL 16</u> 19 <u>72</u> and that in <u>(X)</u> (our) opinion death occurred on the date and hour and from the causes stated above. <u>(X)</u> (We) (did) <u>(X)</u> view the body after death.									
23A. SIGNATURE <u>Rodolfo P. Velasco</u> <u>M.D.</u> DEGREE				23B. DATE SIGNED		23C. PHYSICIAN'S NAME (Type) <u>RODOLFO P. VELASCO</u> DEGREE			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>				24B. DATE <u>4/17/72</u>		24C. NAME OF CEMETERY or CREMATORY <u>Crestlawn</u>		24D. LOCATION (City, town, or county) (State) <u>Ellicott City, Maryland</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>APR 18 1972</u>				25B. NAME OF REGISTRAR <u>John E. Taylor, MD</u>		25C. FUNERAL DIRECTOR <u>Witzke, 2630 Edmondson Avenue</u> ADDRESS <u>21228</u>			

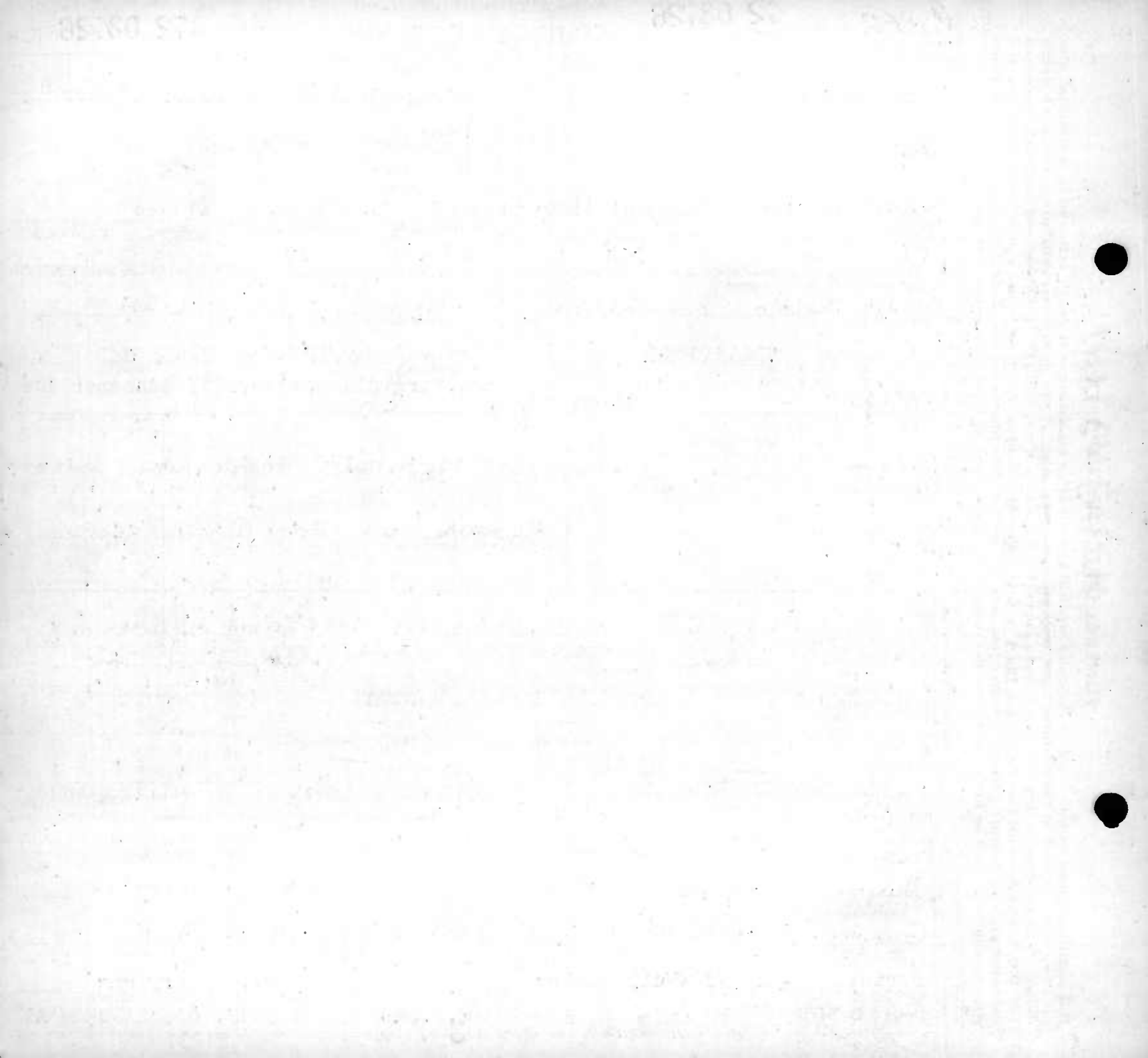
5-10-1972 - Correction form from Funeral Director (Witzke, 1630 Edmondson Ave., Balto., Md. 28

HRS

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 03726	
BIRTH NO.				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print)		(Stanislaus Blaszkowski)		2. DATE AND HOUR OF DEATH 4/17/72 1245 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 43 South Baltimore General Hospital				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 2611 C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 1115 S. Clinton Street	
5. SEX M	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/14/94	9. AGE (In years last birthday) 77	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bridge Builder		10B. KIND OF BUSINESS OR INDUSTRY construction		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME George BLASZKOWSKI		14. MOTHER'S MAIDEN NAME Mary MANIEWSKI MANIEWSKI	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, not unknown) (If yes, give war or dates of service) Unknown		16. SOCIAL SECURITY NO. 216-09-5967A		17. INFORMANT'S ADDRESS Mrs. Virginia Hammen, 6717 Bessemer Ave chart	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). Cellulitis of left arm 4 weeks				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Metabolic Encephalopathy unknown					
(B) DUE TO, OR AS A CONSEQUENCE OF: Hypoxia of Emphysema years					
(C) _____					
19A. DATE OF OPERATION 2-2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED -		20A. AUTOPSY? (Yes or No) yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) no		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) -		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) no	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) -		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? -	
22. I certify that (I) (this hospital) attended the deceased from 3/29 1972 to 4/17 1972, that (I) (we) last saw the deceased alive on 4/17 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Gwynne L. Horwits, M.D. DEGREE				23B. DATE SIGNED 4/17/72	
23C. PHYSICIAN'S NAME (Type) Gwynne L. Horwits, M.D. DEGREE				23D. ADDRESS 2007 Sulgrave Ave., Balto., Md.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4/20/72		24C. NAME OF CEMETERY or CREMATORY Holy Rosary	
24D. LOCATION Baltimore, Maryland		24E. NAME OF CEMETERY or CREMATORY Holy Rosary		24F. LOCATION Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. APR 18 1972		25B. NAME OF REGISTRAR M. F. SADOWSKI & SONS, 1808 EASTERN AVE		25C. FUNERAL DIRECTOR M. F. SADOWSKI & SONS, 1808 EASTERN AVE	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 03727	
7-150 BIRTH NO. 1. NAME OF DECEASED (Type or Print) FABIAN, Michael		CERTIFICATE OF DEATH 2. DATE AND HOUR OF DEATH 4/17/72 6:30 a.m.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 33 The Johns Hopkins Hospital		4. USUAL RESIDENCE (Where deceased lived, If institution; residence before admission) A. STATE Maryland B. COUNTY 202 C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 412 S. Regester Street			
5. SEX Male	6. RACE Cauc.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/14/94	9. AGE (In years last birthday) 77	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Janitor Ret.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Janitor Ret.		10B. KIND OF BUSINESS OR INDUSTRY Apartment Bldg.		11. BIRTHPLACE (State or foreign country) Austria	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Paul X Powell Fabian		14. MOTHER'S MAIDEN NAME Victoria Rogowski			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No -		16. SOCIAL SECURITY NO. 275-36-0576		17. INFORMANT Mary A. Fabian, 412 S. Regester St	
CAUSE OF DEATH					
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: CHRONIC OBSTRUCTIVE LUNG DISEASE (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: Possible Bronchogenic Ca			
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). 19A. DATE OF OPERATION 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 20A. AUTOPSY? (Yes or No) 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? NO					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (nearly medical examined)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from April 17 1972 to April 17 1972 that (1) (we) last saw the deceased alive on April 17 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE 		23B. DATE SIGNED 4/17/72		23C. PHYSICIAN'S NAME (Type) 23D. ADDRESS MICHAEL KARPFF M.D. 3010 S. HOPKINS HOSP	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4/19/72		24C. NAME OF CEMETERY or CREMATORY Sacred Heart of Mary	
24D. LOCATION (City or county) (State) Baltimore, Maryland		25A. DATE REC'D BY HEALTH DEPT. 25B. NAME OF REGISTRAR 25C. FUNERAL DIRECTOR ADDRESS APR 18 1972 M. F. SADOWSKI & SONS, 1808 EASTERN AVE			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

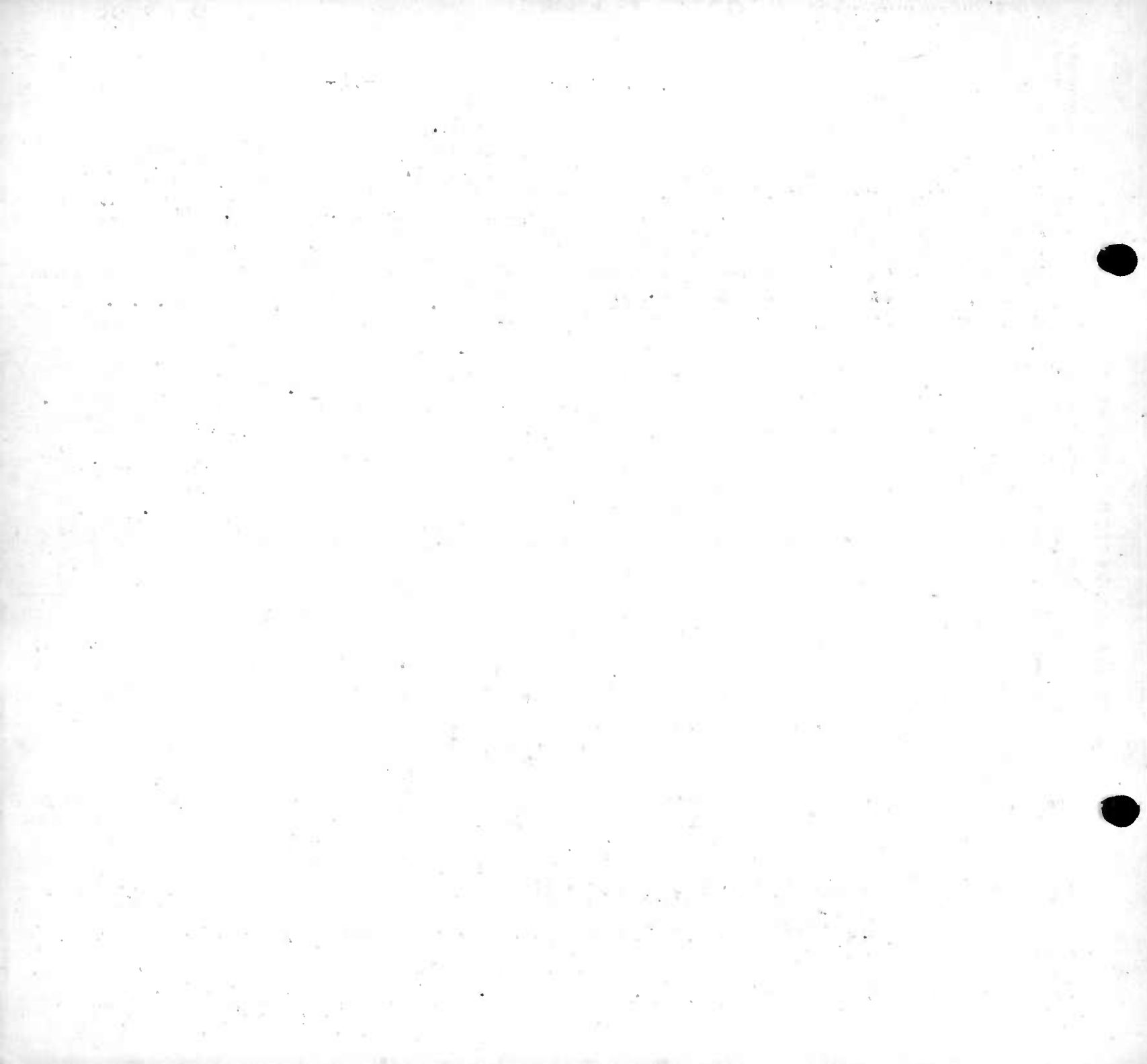
BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

REG. NO.

72 03728

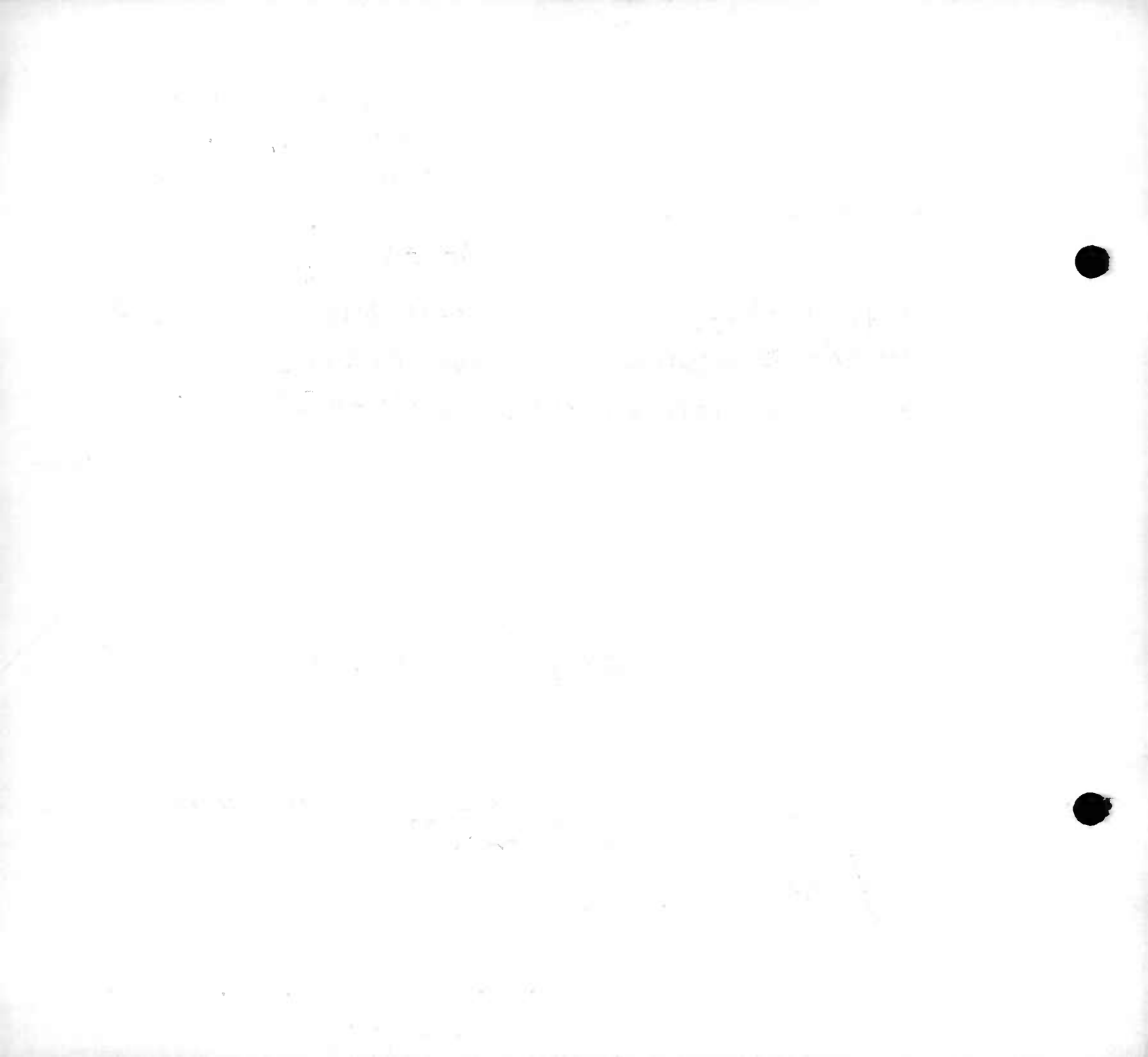
BIRTH NO. 72 03728		1. NAME OF DECEASED (Type or Print) James A. Adams		2. DATE AND HOUR OF DEATH 4-15-72	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 1921 Druid Hill Avenue		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY 1403		C. CITY OR TOWN Balto.	
5. SEX Male		6. RACE Negroid		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH 6-25-94		9. AGE (In years lost birthday) 77		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired	
11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME	
14. MOTHER'S MAIDEN NAME Bessie		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 214303128	
17. INFORMANT Zelma Hughes		ADDRESS 3452 Auchentoroly Ter.		18. 412.31 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH ASHD to probably primary cardiac arrest (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: ASHD (B) DUE TO, OR AS A CONSEQUENCE OF: (C) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH minutes several years	
MEDICAL CERTIFICATION					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 1/5 1972 to 4/14 1972, that (I) (we) last saw the deceased alive on 2/22 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Eliah Saunders DEGREE				23B. DATE SIGNED 4/17/72	
23C. PHYSICIAN'S NAME (Type) ELIAH SAUNDERS DEGREE				23D. ADDRESS 2300 Garrison Ave. Balto. Md.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4-18-72		24C. NAME OF CEMETERY OR CREMATORY Mt. Auburn Cem.	
24D. LOCATION Baltimore, Md.		25A. DATE REC'D BY HEALTH DEPT. APR 18 1972		25B. NAME OF REGISTRAR K. E. Taylor, M.D.	
25C. FUNERAL DIRECTOR V. Bailey		ADDRESS Kelson F.H. 1348 Calhoun Street			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

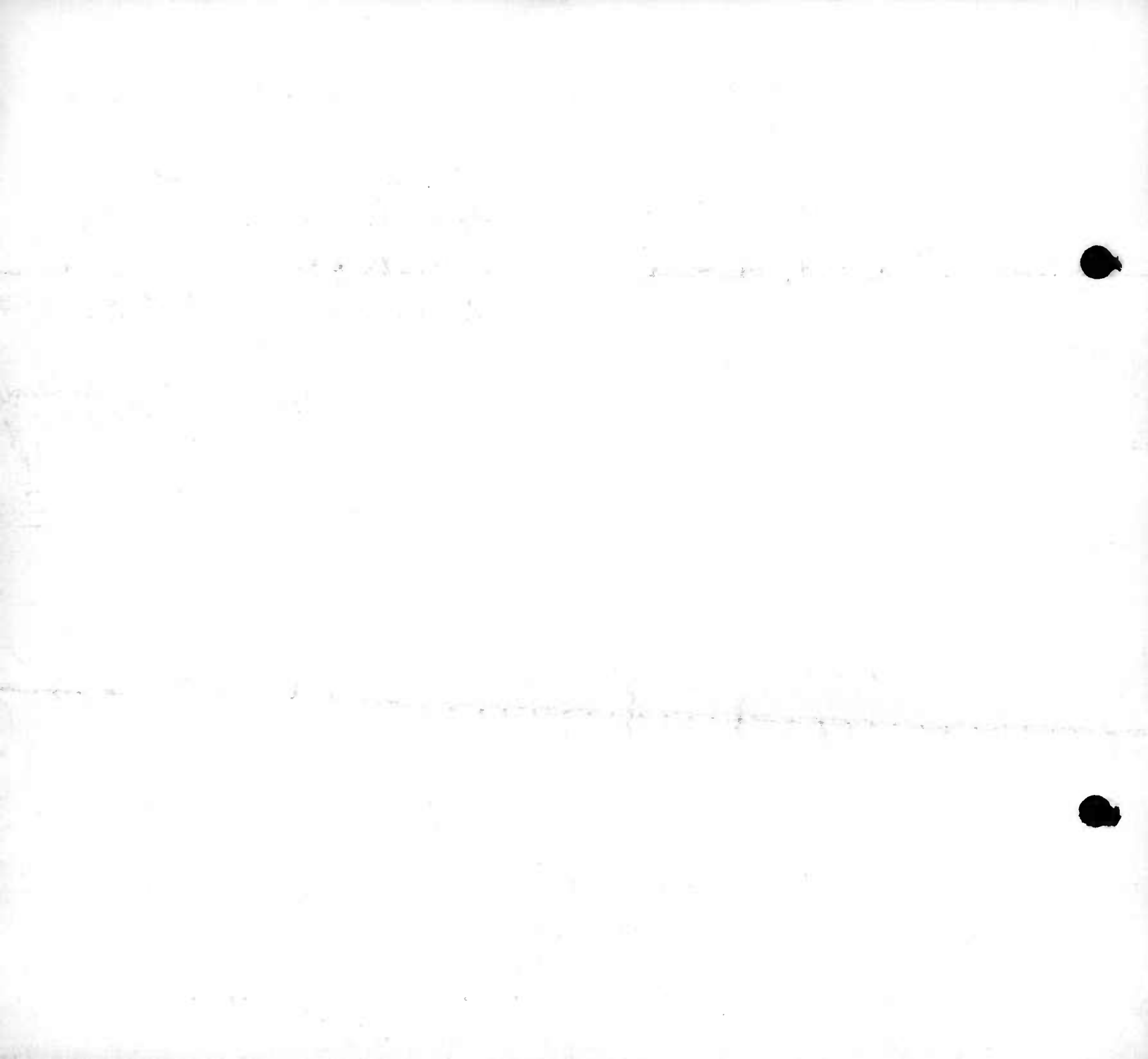
BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. <u>72 03729</u>	
BIRTH NO. <u>72 03729</u>		1. NAME OF DECEASED (Type or Print) <u>Edward Randall</u>		2. DATE AND HOUR OF DEATH <u>4/15/72 9:15pm</u>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>45 The Good Samaritan Hospital</u>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Md.</u> B. COUNTY <u>521</u> C. CITY OR TOWN <u>Baltimore 21202</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>251 Colvin St.</u>		
5. SEX <u>M</u>	6. RACE <u>B</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-28-27</u>	9. AGE (In years last birthday) <u>44</u>	If Under 1 Tr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>unemployed veteran</u>			10B. KIND OF BUSINESS OR INDUSTRY		
13. FATHER'S NAME <u>THOMAS RANDALL</u>			14. MOTHER'S MAIDEN NAME <u>IVA CARTER</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>yes approx 1946</u>			16. SOCIAL SECURITY NO. <u>220144135</u>		
17. INFORMANT <u>Barbara-Colvin St. Randall wife + brothers</u>			ADDRESS		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) <u>CARDIO-Pulmonary Arrest</u>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 hr</u>		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>① COPD-PULMONARY; ② CHRONIC RESPIRATORY INSUFFICIENCY</u>		
			(B) DUE TO, OR AS A CONSEQUENCE OF: <u>③ CHRONIC BRONCHITIS 2 yrs</u>		
			(C) <u>④ ATYPICAL MYOBACTERIAL 8 yrs</u>		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <u>⑤ POSS. IMI. ⑥ POSS. PULMONARY EMBOLISM</u>					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>3-2</u> 19 <u>72</u> to <u>4-15</u> 19 <u>72</u> that (I) (we) lost saw the deceased alive on <u>4-15</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>[Signature]</u>				23B. DATE SIGNED <u>4/15/72</u>	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>4-20-72</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Arbutus Mem. Pk.</u>	
24D. LOCATION (City, town, or county) (State) <u>Balto., Md.</u>		25A. DATE REC'D BY HEALTH DEPT. <u>APR 18 1972</u>			
25B. NAME OF REGISTRAR <u>John E. Talbot, M.D.</u>		25C. FUNERAL DIRECTOR <u>V. Bailey</u>		ADDRESS <u>1348 Calhoun Street</u>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 03730			
BIRTH NO. 72 03730				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <u>Stokes, Mary A.</u>				2. DATE AND HOUR OF DEATH <u>4/17/72</u> <u>10 a</u> M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <u>46 Lutheran Hospital</u> <u>Baltimore, Md. 21216.</u>				A. STATE <u>Maryland</u>		B. COUNTY <u>1606</u>	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <u>7</u>				6. RACE <u>B</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	
8. DATE OF BIRTH <u>6-20-30</u>				9. AGE (In years last birthday) <u>41</u>		10. UNDER 1 Yr. Months: Days: Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>				13. FATHER'S NAME <u>Howard Green</u>			
14. MOTHER'S MAIDEN NAME <u>Rosie</u>				15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u>			
16. SOCIAL SECURITY NO.				17. INFORMANT <u>George Stokes</u>			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Uraemia with Diabetes mellitus</u>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 years</u>			
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>II</u>				20. IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>(Kimmel-Siegel Wilson Syndrome)</u>			
21. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				22. I certify that (I) (this hospital) attended the deceased from <u>4/16/1972</u> to <u>4/17/1972</u> and that (I) (we) last saw the deceased alive on <u>4/17/1972</u> and that (I) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <u>Anjana Doshi MD</u>				23B. DATE SIGNED <u>4/17/72</u>			
23C. PHYSICIAN'S NAME (Type) <u>ANJANA DOSHI MD</u>				23D. ADDRESS <u>1348 Calhoun Street</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>				24B. DATE <u>2-21-72</u>			
24C. NAME OF CEMETERY or CREMATORY <u>Arbutus Mem. Pk.</u>				24D. LOCATION (City, town, or county) (State) <u>Balto., Md.</u>			
25A. DATE REC'D BY HEALTH DEPT. <u>APR 18 1972</u>				25B. NAME OF REGISTRAR <u>Robert E. Fisher, MD</u>			
25C. FUNERAL DIRECTOR <u>W. Bailey</u>				25D. ADDRESS <u>1348 Calhoun Street</u>			



FUNERAL DIRECTOR: IMPORTANT

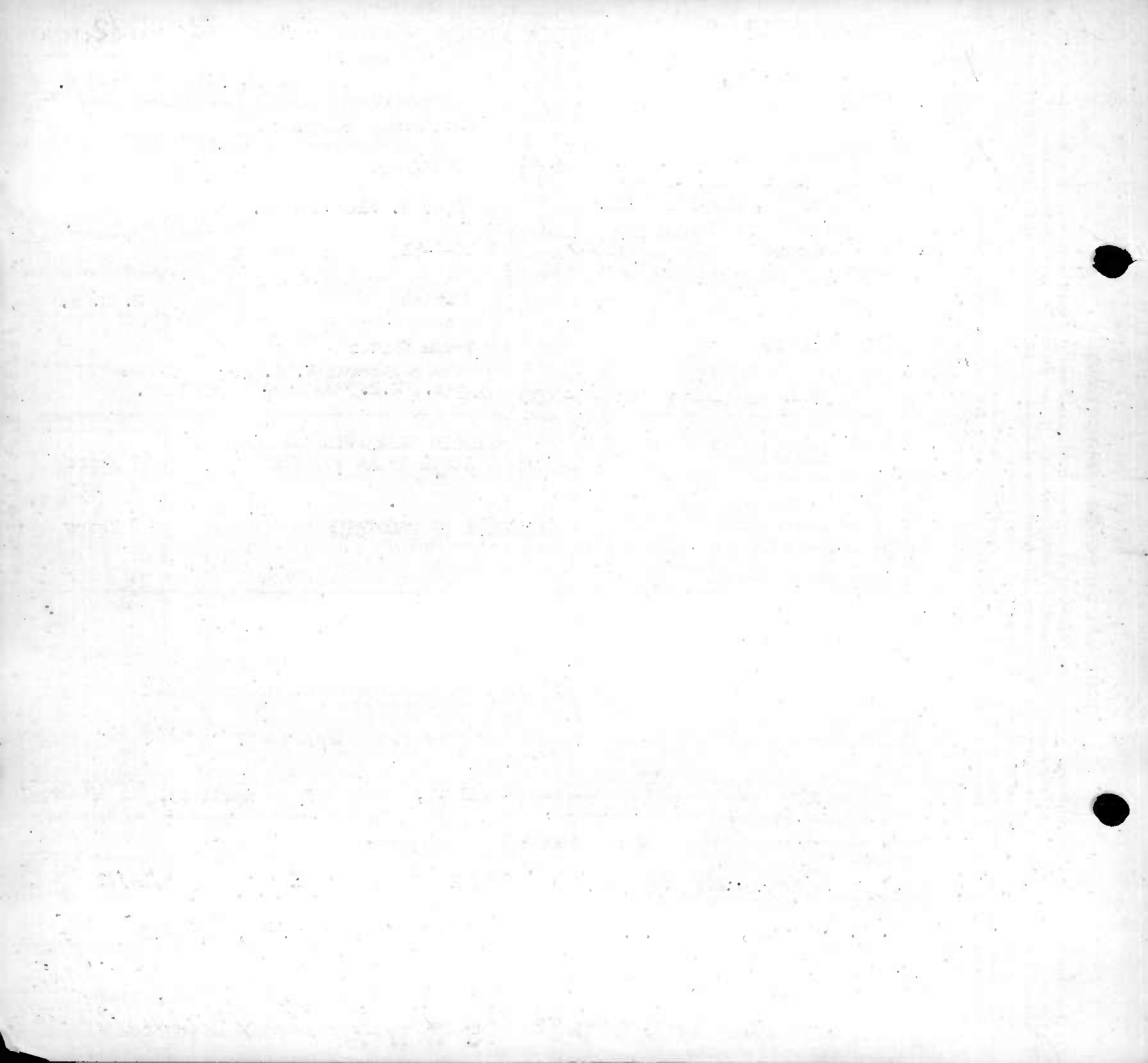
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 03731	
CERTIFICATE OF DEATH					
BIRTH NO. 72 03731					
1. NAME OF DECEASED (Type or Print) ROBINSON, LAWRENCE D.		2. DATE AND HOUR OF DEATH 4-16-72 12:15 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) SINAI HOSPITAL		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD., B. COUNTY BALTIMORE C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 2509 MC CULLOUGH ST. 21217			
5. SEX M	6. RACE BLACK	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-30-12	9. AGE (In years last birthday) 59	10. Under 1 Yr. Months Days If Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Teacher		10B. KIND OF BUSINESS OR INDUSTRY Public Schools		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Daniel Robinson		14. MOTHER'S MAIDEN NAME Louise Trusty	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) UNKNOWN		16. SOCIAL SECURITY NO.		17. INFORMANT Elsie Robinson-wife	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH CARCINOMA OF THE NASOPHARYNX — (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: METASTATIC (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 21 MO.		19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			
19A. DATE OF OPERATION NONE		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) NO		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (this hospital) attended the deceased from 4-5 1972 to 4-16 1972 that (we) lost saw the deceased alive on 4-16 1972 and that in (our) opinion death occurred on the date and hour and from the causes stated above. (I) (did) view the body after death.					
23A. SIGNATURE Ronald P. Byank, M.D. 9006				23B. DATE SIGNED 4-16-72	
23C. PHYSICIAN'S NAME (Type) R.P. BYANK, M.D.		23D. ADDRESS SINAI HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4-20-72		24C. NAME OF CEMETERY OR CREMATORY New Cathedral Cem.	
24D. LOCATION Baltimore, Md.		25A. DATE REC'D BY HEALTH DEPT. APR 18 1972			
25B. NAME OF REGISTRAR Jesse E. Taylor, M.D.		25C. FUNERAL DIRECTOR V. Bailey 1348 Calhoun Street			

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>72 03732</u>
BIRTH NO. 1. NAME OF DECEASED (Type or Print) <u>BARNETT, PURNELL</u>		2. DATE AND HOUR OF DEATH <u>April 13, 1972</u> <u>4:45 P.</u> M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>23 Veterans Administration Hospital</u> <u>3900 Loch Raven Boulevard</u> <u>Blatimore, Maryland 21218</u>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore</u> 1547 C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>2305 N. Ellamont St.</u>		
5. SEX <u>Male</u>	6. RACE <u>Negroid</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-2-91</u>	9. AGE (In years lost birthday) <u>80</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Cook</u>		10B. KIND OF BUSINESS OR INDUSTRY 		
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		
13. FATHER'S NAME <u>Philip Barnett</u>		14. MOTHER'S MAIDEN NAME <u>Verda Carter</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>Yes</u> <u>7-18-18 to 1-9-19</u>		16. SOCIAL SECURITY NO. <u>215-03-0223</u>		
17. INFORMANT <u>Records V. A. Hospital</u> ADDRESS <u>Balto., M.D. 3900 Loch Raven Blvd.</u>				
18. CAUSE OF DEATH				
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CHRONIC RENAL DISEASE WITH ACUTE RELAN FAILURE (A) IMMEDIATE CAUSE <u>ACUTE RELAN FAILURE</u> DUE TO, OR AS A CONSEQUENCE OF: (B) CARCINOMA OF PROSTATE DUE TO, OR AS A CONSEQUENCE OF: (C)		
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>27 Years</u> <u>8 Years</u>				
II				
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		
20A. AUTOPSY? (Yes or No) 		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) 		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		
21F. HOW DID INJURY OCCUR?				
22. I certify that <u>XX</u> (this hospital) attended the deceased from <u>April 11,</u> 19 <u>72</u> to <u>April 13,</u> 19 <u>72</u> , that (I) (we) last saw the deceased alive on <u>April 13,</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. <u>XX</u> (We) (did) <u>not</u> view the body after death.				
23A. SIGNATURE <u>C. L. Cromwell, M.D.</u> DEGREE				23B. DATE SIGNED <u>4/15/72</u>
23C. PHYSICIAN'S NAME (Type) <u>C. L. CROMWELL,</u> M.D. DEGREE				23D. ADDRESS <u>VA HOSPITAL, BALTIMORE, MARYLAND</u>
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>4/19/72</u>		
24C. NAME OF CEMETERY or CREMATORY <u>Mt. Auburn</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore Md.</u>		
25A. DATE REC'D BY HEALTH DEPT. <u>APR 18 1972</u>		25B. NAME OF REGISTRAR <u>Robert E. Jones, M.D.</u>		
25C. FUNERAL DIRECTOR <u>Wilmington</u>		25D. ADDRESS <u>1727 N. Mount</u>		



FUNERAL DIRECTOR: IMPORTANT

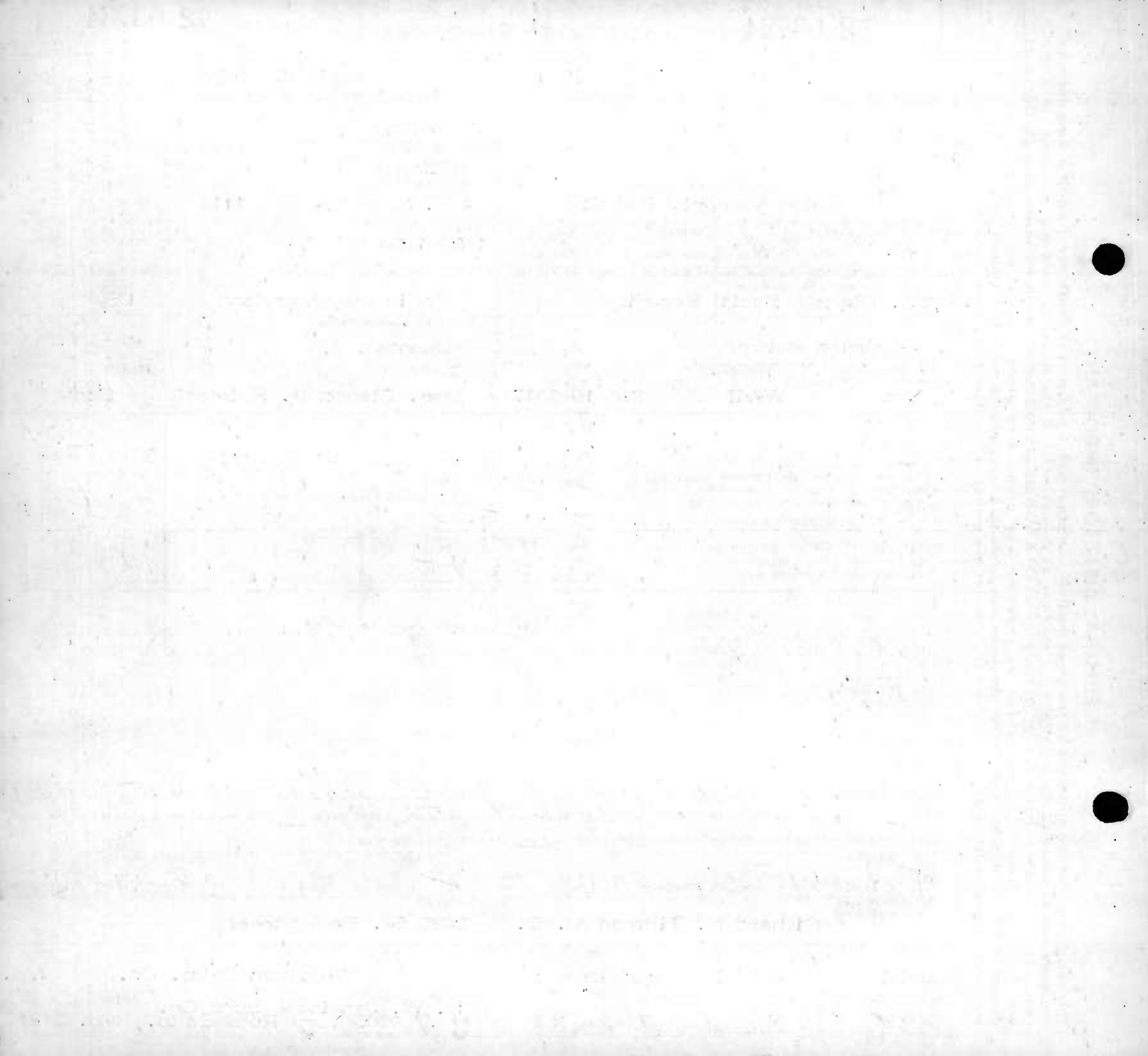
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Baltimore City Health Department				REG. NO. 72 03733	
BIRTH NO. 72 03733		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) Clarence Robert Lokeman			2. DATE AND HOUR OF DEATH April 12, 1972 10 P M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) US PHS Hospital 3100 Wyman Parkway			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY 1607 C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 1528 Rosedale St.		
5. SEX M	6. RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5/30/13	9. AGE (in years last birthday) 58	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mechanic		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Md.	
13. FATHER'S NAME Clarence Lokeman			14. MOTHER'S MAIDEN NAME Edna Ward		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 215-05-0852		17. INFORMANT ADDRESS Records- US PHS Hospital, Balto, Md.	
18. CAUSE OF DEATH I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Bronchopneumonia ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). Glioblastoma multiforme of brain			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Days Years		
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Mar. 11 19 72 to Apr. 12 19 72 , that (I) (we) last saw the deceased alive on Apr. 12 19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE John Sutherland, M.D. DEGREE				23B. DATE SIGNED 4/13/72	
23C. PHYSICIAN'S NAME (Type) John Sutherland, MD		23D. ADDRESS US PHS Hospital, Balto, Md.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 4/17/72	24C. NAME OF CEMETERY OR CREMATORY Arbutus Mem. Ch. Baltimore		24D. LOCATION (City, town, or county) (State) MD.	
25A. DATE REC'D BY HEALTH DEPT. APR 18 1972		25B. NAME OF REGISTRAR Robert E. Fisher, M.D.		25C. FUNERAL DIRECTOR W. H. Bright ADDRESS 1727 N. Mount St.	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

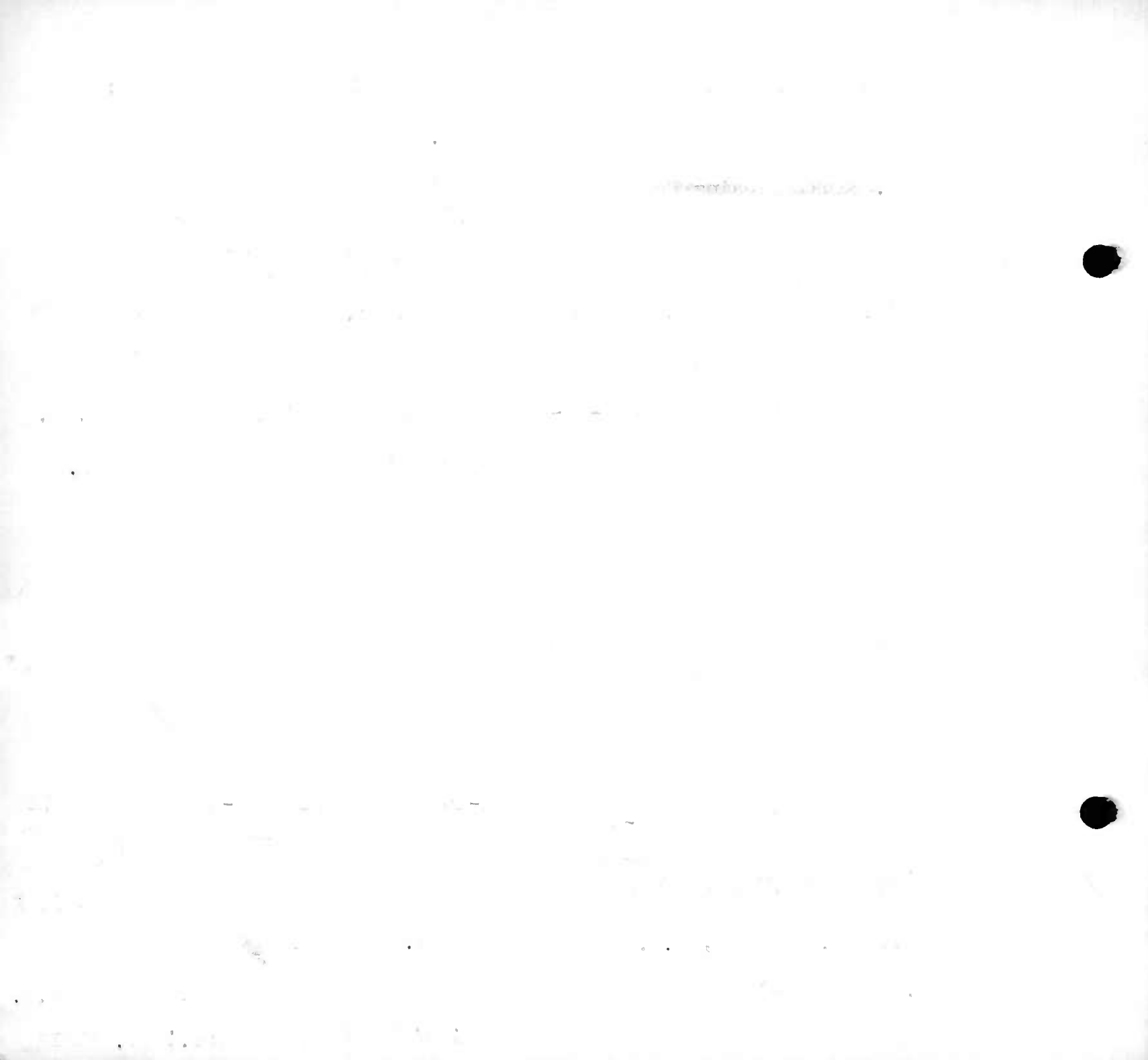
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>72 03734</u>	
72 03734		CERTIFICATE OF DEATH			
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		Charles Edward Reimer		April 15, 1972 7:30 P. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION 44 Union Memorial Hospital			A. STATE Maryland B. COUNTY 1202		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER 4 E. 32nd Street 21218		
5. SEX M	6. RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-30-1904	9. AGE (In years last birthday) 67	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret'd. Clerk Social Security		10B. KIND OF BUSINESS OR INDUSTRY Security		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Charles Reimer		14. MOTHER'S MAIDEN NAME Unknown	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes WWII		16. SOCIAL SECURITY NO. 212-10-3517		17. INFORMANT Mrs. Clagett R. Reimer	
				ADDRESS Same	
18. <u>4-10-72</u> I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Myocardial infarction</u> (B) <u>Previous myocardial infarctions</u> (C) <u>A.S.C.V.D.</u>		
			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>minutes</u> <u>3 + 4 years</u> <u>10 years</u>		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>Renal insufficiency</u>					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>July</u> 19 <u>68</u> to <u>April 15</u> 1972, that (I) (we) last saw the deceased alive on <u>April 10</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Richard N. Tillman, MD</u>				23B. DATE SIGNED <u>4-17-72</u>	
23C. PHYSICIAN'S NAME (Type) Richard N. Tillman M. D.				23D. ADDRESS 3035 St. Paul Street	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4-18-72		24C. NAME OF CEMETERY or CREMATORY Woodlawn	
				24D. LOCATION (City, town, or county) (State) Woodlawn Balto. Co. Md.	
25A. DATE REC'D BY HEALTH DEPT. APR 18 1972		25B. NAME OF REGISTRAR <u>Edgar E. Taylor, M.D.</u>		25C. FUNERAL DIRECTOR H. W. Jenkins & Sons Co. 4905 York Road Balto., Md. 21212	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>72 03735</u>	
BIRTH NO. <u>72 03735</u>		CERTIFICATE OF DEATH			
1. NAME OF DECEASED Type or Print <u>Irvin DISSINGER</u>		2. DATE AND HOUR OF DEATH <u>16 April 72</u> <u>8:15 P</u> M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <u>90 Mt. Sinai Nursing Home</u> IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>Md.</u> B. COUNTY <u>2101</u>			
		C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER <u>611 Scott Street 21220</u>			
5. SEX <u>M</u>	6. RACE <u>C</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-25-1896</u>	9. AGE in years last birthday <u>75</u>	10. Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ret'd. Carpenter</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Carpentry</u>		11. BIRTHPLACE (State or foreign country) <u>Auburn, Pa.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>John Dissinger</u>			
14. MOTHER'S MAIDEN NAME <u>Elizabeth Hunnel</u>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>Yes</u> <u>WWI</u>			
16. SOCIAL SECURITY NO. <u>207-09-1577</u>		17. INFORMANT <u>Stretch Evans Funeral Home N. J.</u>			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenic, etc. It means the disease, injury or complication which caused death.) <u>Brain tumor</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>II</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>mos.</u> (B) DUE TO, OR AS A CONSEQUENCE OF: (C)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION <u>2-20</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>yes</u>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) 1 Month) (Day) (Year) 1 Hour		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>2-20</u> 19 <u>72</u> to <u>4-14</u> 19 <u>72</u> that (I) (we) last saw the deceased alive on <u>4-14</u> 19 <u>72</u> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Arthur M. Wagner, M.D.</u>		23B. DATE SIGNED <u>16 April 72</u>		23C. PHYSICIAN'S NAME (Type) <u>Arthur M. Wagner, M.D.</u>	
23D. ADDRESS <u>Univ. Hospital</u>		24A. BURIAL CREMATION, REMOVAL (Specify) <u>Rem. Burial</u>			
24B. DATE <u>4-18-72</u>		24C. NAME of CEMETERY or CREMATORY <u>Locustwood</u>		24D. LOCATION <u>Cherry Hill, N.J.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>APR 18 1972</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor, R.D.</u>		25C. FUNERAL DIRECTOR <u>H. W. Jenkins & Sons Co.</u>	
				ADDRESS <u>34905 York Road Balto., Md. 21212</u>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 72 03736				BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		REG. NO. 72 03736	
1. NAME OF DECEASED (Type or Print) Guliano, Joseph				2. DATE AND HOUR OF DEATH 4-16-72 A M.					
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE NY B. COUNTY 129					
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) USPHS HOSPITAL 3100 WYMAN PARK DRIVE BALTIMORE, MARYLAND-21211				C. CITY OR TOWN MIDDLETOWN, NY		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			
5. SEX M 6. RACE WHITE 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				B. DATE OF BIRTH DEC. 6, 1905		9. AGE (in years last birthday) 66		If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RET-CUTTER				10B. KIND OF BUSINESS OR INDUSTRY CARMENT		11. BIRTHPLACE (State or foreign country) NY/USA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME (DEC) SALVATORE GULIANO				14. MOTHER'S MAIDEN NAME (DEC) PARATORE, MARIE					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NONE				16. SOCIAL SECURITY NO. 117-05-2100		17. INFORMANT ADDRESS ADMISSION SHEET U.S.P.H.S. HOSP.			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH BRONCHOPNEUMONIA (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. HOOGKIN'S DISEASE				CAUSE OF DEATH BRONCHOPNEUMONIA (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: HOOGKIN'S DISEASE (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Days Months			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).									
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR					
22. I certify that (I) (this hospital) attended the deceased from _____ 19 _____ to _____ 19 _____ that (I) (we) last saw the deceased alive on _____ 19 _____ and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE John C. Sutherland MD				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED APRIL 16, 1972			
23C. PHYSICIAN'S NAME (Type) JOHN C. SUTHERLAND MD				23D. ADDRESS U.S.P.H.S. Hospital BALTIMORE 3100 WYMAN PARK DR.					
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 4/21/72		24C. NAME of CEMETERY or CREMATORY Mt Olivet Cemetery		24D. LOCATION (City, town, or county) (State) Frankfort, New York			
25A. DATE REC'D BY HEALTH DEPT. APR 18 1972		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR John Funeral Ser. 2380 PACIFIC STREET BROOKLYN					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				CERTIFICATE OF DEATH		REG. NO. 72 03737		
BIRTH NO. 72 03737				1. NAME OF DECEASED (Type or Print) COLLINS, DOLORES J.		2. DATE AND HOUR OF DEATH 4/13/72 12:00 Noon M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Balto. B. COUNTY Balto (?)		5. CITY OR TOWN Balto. ESSEX		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 48 Maryland General Hosp.				D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		E. STREET AND NUMBER 319 Maryland Ave.		
5. SEX F	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 12-19-15	9. AGE (In years last birthday) 56	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) assembly			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME WILLIAM SLAINE				14. MOTHER'S MAIDEN NAME MARGARET TUDER				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO.		17. INFORMANT Pt's chart.		ADDRESS	
18. 154.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Suppurative Generalized peritonitis (B) DUE TO, OR AS A CONSEQUENCE OF: Operation, defuncting Colostomy (C) Cancer Rectum with bowel obstruction				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).								
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?				
22. I certify that (I) (this hospital) attended the deceased from 19 to 19 that (I) (we) last saw the deceased alive on 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.								
23A. SIGNATURE H. Ziegler M.D.				23B. DATE SIGNED 4/13/72		23C. PHYSICIAN'S NAME (Type) J. H. Ziegler M.D.		
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 4/17/72		24C. NAME of CEMETERY or CREMATORY SACRED HEART		24D. LOCATION (City, town, or county) BALTO. MD. (State)		
25A. DATE REC'D BY HEALTH DEPT. APR 18 1972		25B. NAME OF REGISTRAR R. E. J. O. J.		25C. FUNERAL DIRECTOR J. B. CONNELLY		ADDRESS 300 MACE		



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 72 03738		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 03738	
1. NAME OF DECEASED (Type or Print) WINDER, MRS. LAETITIA D.			2. DATE AND HOUR OF DEATH 4/14/72 2 P.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) EDGEWOOD NURSING HOME 6000 BELLONA AVE. BALTIMORE, MD. 21212			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MD. B. COUNTY 2714		
5. SEX F 6. RACE W 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH 11-1-1887		9. AGE (In years last birthday) 84
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Baltimore, Md.
12. CITIZEN OF WHAT COUNTRY USA			13. FATHER'S NAME Harry V. Duff		
14. MOTHER'S MAIDEN NAME Florence Sindall			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		
16. SOCIAL SECURITY NO. 214-46-9568-T			17. INFORMANT Mrs. Florence J. Stroud		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) II. Anterior Sclerotic Heart			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 yrs.		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Diabetes Mellitus			DUE TO, OR AS A CONSEQUENCE OF: 10 yrs.		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). Chronic Brain Damage			DUE TO, OR AS A CONSEQUENCE OF: Generalized Anterior Sclerosis		
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this person) attended the deceased from March 1971 to April 14 1972 that (I) lost saw the deceased alive on April 13 1972 and that in (my) own opinion death occurred on the date and hour and from the causes stated above. (I) was (did) not view the body after death.					
23A. SIGNATURE Earl L. Chambers				23B. DATE SIGNED 4/14/72	
23C. PHYSICIAN'S NAME (Typo) Earl L. Chambers				23D. ADDRESS 100-W. Colfax Spring La. Md.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4/17/72		24C. NAME OF CEMETERY OR CREMATORY Druid Ridge Cemetery	
24D. LOCATION Reistertown Rd Pikesville Md.		25A. DATE REC'D BY HEALTH DEPT. APR 18 1972		25B. NAME OF REGISTRAR Earl L. Chambers, M.D.	
25C. FUNERAL DIRECTOR McShull		25D. ADDRESS 6500 York Rd			

11. *Antennae* *Antennae* *Antennae*
Antennae *Antennae* *Antennae*
Antennae *Antennae* *Antennae*
Antennae *Antennae* *Antennae*
 No.

21. 10/15

Sept 13 1895

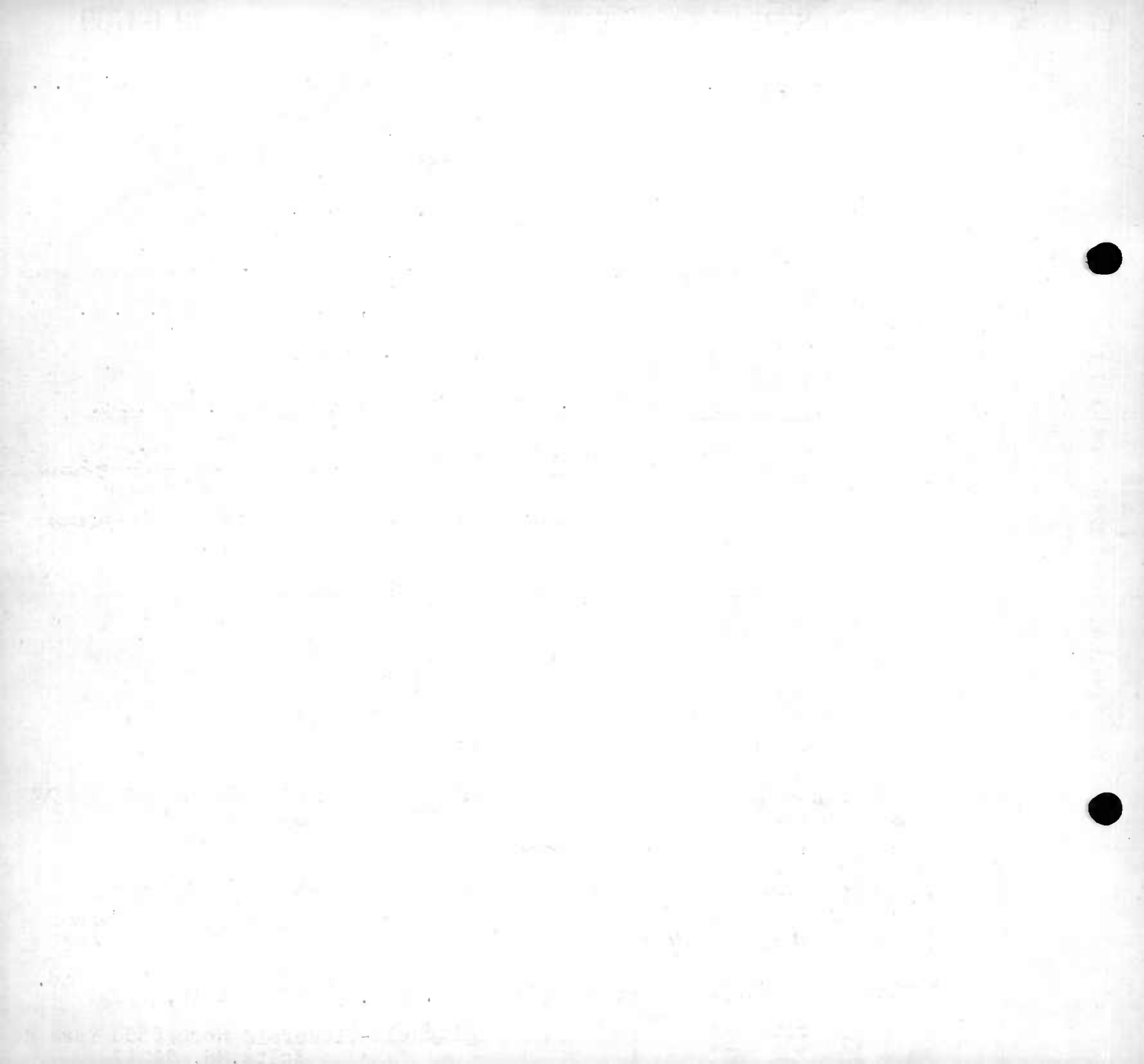
Vol 1 L Chamber
Vol 2 Chamber

100-11. 100-11. 100-11.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>72 03739</u>	
BIRTH NO. <u>72 03739</u>				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <u>Irene T. Holden</u>			2. DATE AND HOUR OF DEATH <u>4-13-72</u> <u>6:30 P.M.</u>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>91 Keswick Home for Incurables</u>			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>2712</u> C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>310 E. Melrose Avenue</u>		
5. SEX <u>Female</u>	6. RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8/31/1882</u>	9. AGE (In years last birthday) <u>89 yrs.</u>	If Under 1 Yr. Months: Days: Hours: Min. If Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>	
13. FATHER'S NAME <u>Henry Southers Thearle</u>			14. MOTHER'S MAIDEN NAME <u>Sally J. Scott</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>215-12-6531</u>		17. INFORMANT ADDRESS <u>Keswick Records 700 W. 40th. St.</u>	
18. <u>737.91</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <u>Encephalomalacia</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last, <u>II</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <u>cerebral arteriosclerosis</u>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>5 years</u> <u>5 years</u>		
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>NO</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from <u>Feb 14</u> 19 <u>68</u> to <u>April 13</u> 19 <u>72</u> , that (2) (we) lost saw the deceased alive on <u>April 13</u> 19 <u>72</u> and that in (3) (our) opinion death occurred on the date and hour and from the causes stated above. (4) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>W.B. Daniels, Jr. M.D.</u>				23B. DATE SIGNED <u>4/14/72</u>	
23C. PHYSICIAN'S NAME (Type) <u>W.B. DANIELS, Jr. M.D.</u>				23D. ADDRESS <u>Keswick, 700 W. 40th St. Baltimore Md.</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>burial</u>		24B. DATE <u>4/17/72</u>		24C. NAME OF CEMETERY or CREMATORY <u>Dulaney Valley Mem. Grds.</u>	
24D. LOCATION (City, town, or county) (State) <u>Cockeysville, Md.</u>		25A. DATE REC'D BY HEALTH DEPT. <u>APR 18 1972</u>			
25B. NAME OF REGISTRAR <u>Robert E. Taylor, R.D.</u>		25C. FUNERAL DIRECTOR <u>Mitchell-Wiedefeld Home</u>			
25D. ADDRESS <u>6500 York Rd Balto. Md. 21212</u>					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

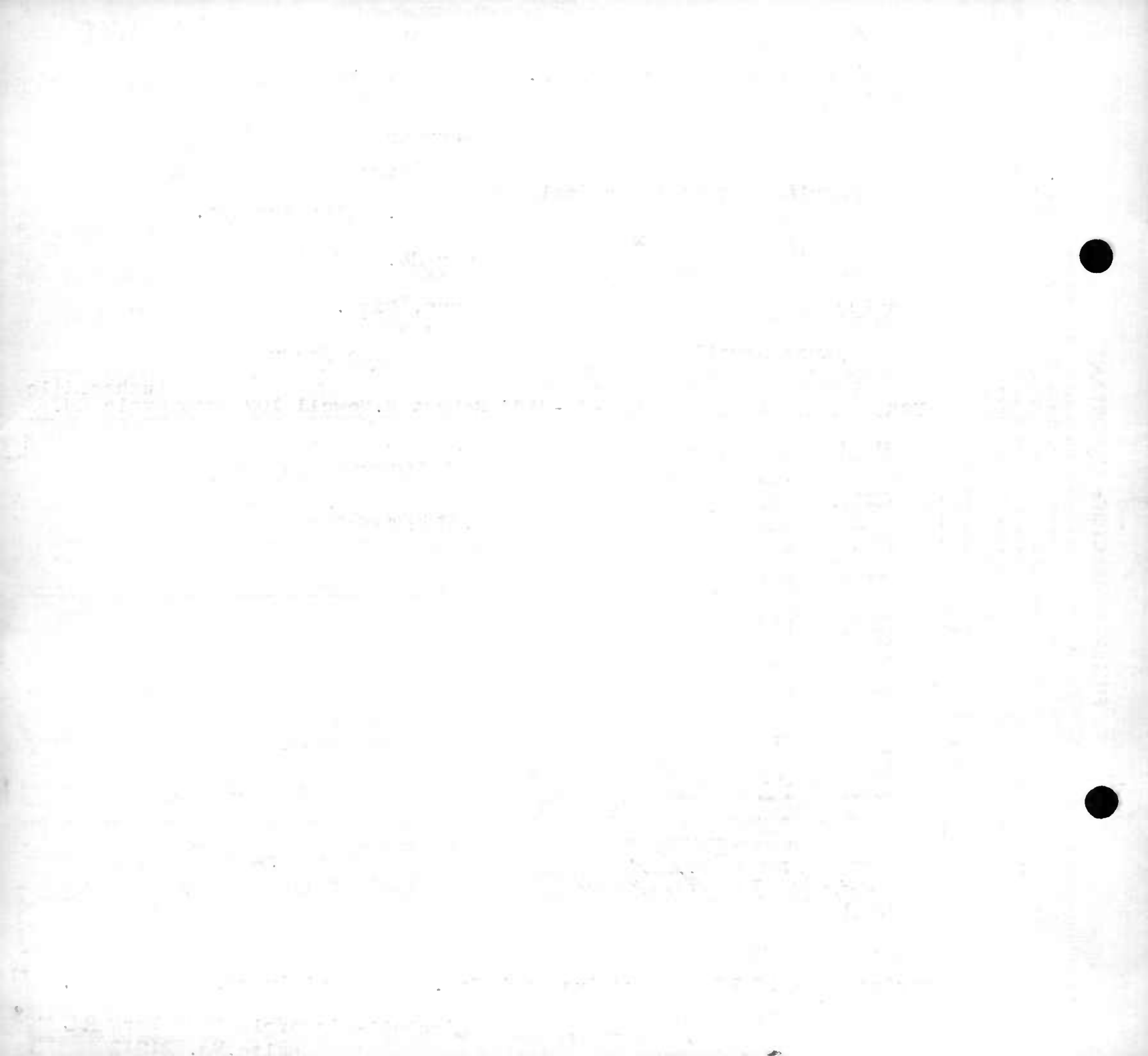
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 03740	
CERTIFICATE OF DEATH					
BIRTH NO. 72 03740					
1. NAME OF DECEASED (Type or Print) <i>McNicholas, Mary S.</i>			2. DATE AND HOUR OF DEATH <i>4/12/72</i> <i>7:59</i> M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <i>Good Samaritan Hosp.</i>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>MD</i> B. COUNTY <i>2748</i>		
			C. CITY OR TOWN <i>Balt.</i>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER <i>1400 Lochner Rd</i>		
5. SEX <i>F</i>	6. RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>5-15-06</i>	9. AGE (in years last birthday) <i>65</i>	If Under 1 Yr. Months Days If Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Homemaker</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>SKANE</i>		11. BIRTHPLACE (State or foreign country) <i>Balto. Md</i>	
13. FATHER'S NAME <i>Wm E. McNicholas</i>			14. MOTHER'S MAIDEN NAME <i>Mary Mc Nicholas</i>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>218-14-7992</i>		17. INFORMANT <i>Mrs. Julia P. Leary</i> ADDRESS <i>405 Stevenson Lane</i>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH <i>28101</i>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) IMMEDIATE CAUSE <i>anaphylaxis</i> DUE TO, OR AS A CONSEQUENCE OF: (B) <i>Myocardial infarction</i> DUE TO, OR AS A CONSEQUENCE OF: (C) <i>CVA, Pericarditis with</i> <i>Subacute cerebellar degeneration</i>		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <i>4/15/72</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>yes</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>4/5/72</i> 19 <i>72</i> to <i>4/12</i> 19 <i>72</i> that (I) (we) last saw the deceased alive on <i>4/12/72</i> and that (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Jewell Ellen</i>			23B. DATE SIGNED <i>4/12/72</i>		23C. PHYSICIAN'S NAME (Type) <i>Jewell ELLER</i>
			23D. ADDRESS <i>Good Samaritan Hospital</i>		23E. DEGREE <i>MD</i>
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>4/15/72</i>		24C. NAME OF CEMETERY or CREMATORY <i>New Cathedral</i>	
				24D. LOCATION (City, town, or county) (State) <i>Baltimore Md</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>APR 18 1972</i>		25B. NAME OF REGISTRAR <i>E. Taylor, M.D.</i>		25C. FUNERAL DIRECTOR <i>Mitchell - Gladio Feld House 6500 York Rd</i>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>72 03741</u>	
BIRTH NO. <u>72 03741</u>		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <u>Sewell, Arthur J.</u>		2. DATE AND HOUR OF DEATH <u>4-12-72</u> <u>10:41 A.M.</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <u>48 Maryland General Hospital</u>		A. STATE <u>Maryland</u>		B. COUNTY <u>Baltimore</u>	
IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION		C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER <u>1124 E. Belvedere Ave.</u>			
5. SEX <u>M</u>	6. RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 28, 1909</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>sales</u>		10B. KIND OF BUSINESS OR INDUSTRY		9. AGE (in years last birthday) <u>62</u>	
11. BIRTHPLACE (State or foreign country) <u>Lynn, Mass.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>James Sewell</u>		14. MOTHER'S MAIDEN NAME <u>Maude Perry</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>yes WW II</u>		16. SOCIAL SECURITY NO. <u>023-05-3134</u>		17. INFORMANT <u>Robert E. Sewell</u>	
				ADDRESS <u>Lutherville 102 Meadowdale Rd.</u>	
18. <u>1621 I</u>		CAUSE OF DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH !This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Carcinoma of Lung</u>			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) <u>E metastasis</u> DUE TO, OR AS A CONSEQUENCE OF:			
		(C) _____			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) 1(Month) 1(Day) 1(Year) 1(Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>2/8</u> 19 <u>72</u> to <u>4/12</u> 19 <u>72</u> that (I) (we) last saw the deceased alive on <u>4/12</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Ronald H. Kulp, M.D.</u>				23B. DATE SIGNED <u>4/15/72</u>	
23C. PHYSICIAN'S NAME (Type) <u>Ronald H. Kulp, M.D.</u>				23D. ADDRESS <u>Baltimore, Md.</u>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		24B. DATE <u>4/15/72</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Lorraine Park Cem.</u>	
24D. LOCATION <u>Baltimore, Md.</u>		25A. DATE REC'D BY HEALTH DEPT. <u>APR 18 1972</u>			
25B. NAME OF REGISTRAR <u>Robert E. Taylor, M.D.</u>		25C. FUNERAL DIRECTOR <u>Mitchell Giedefeld</u>			
25D. ADDRESS <u>6500 York Rd.</u>		25E. CITY <u>Balto. Md.</u>			



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BIRTH NO. 72-02058

REG. NO.

72 03742

1. NAME OF DECEASED (Type or Print) BABY BOY DAWSON <i>A.K.A. CHARLES D. MEILE</i>		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 33 JOHNS HOPKINS HOSPITAL		3. DATE PRONOUNCED DEAD Month Day Year Hour February 1, 1972 4:30 P.M.	
6. SEX Male		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
7. RACE Negro		C. CITY OR TOWN Baltimore	
9. DATE OF BIRTH 1/1/72		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
10. AGE (in years last birthday) 1		E. STREET AND NUMBER 1728 N. Washington Street	
11. BIRTHPLACE (State or foreign country) BALTIMORE, MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME CHARLES MEILE		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CHILD	
15. MOTHER'S MAIDEN NAME MARY DAWSON		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (if yes, give war or dates of service) NO	
17. SOCIAL SECURITY NO. NONE		18. INFORMANT BIRTH CERTIFICATE # 72-02058	
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Cerebral Infarction Secondary to Hypoxia suffered during maternal Hypotension		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). Birth Injury			
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) yes			
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Home	
22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 1728 N. Washington Street		22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.) 11-12-71 ?	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? Mother stabbed while pregnant	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Ronald N. Kornblum, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
24A. BURIAL CREMATION, REMOVAL (Specify) Crementation		24B. DATE 3-12-72	
24C. NAME OF CEMETERY or CREMATORY Medical Examiner Office		24D. LOCATION (City, town, or county) (State) 111 Penn St. Balto., M.D.	
25A. DATE REC'D BY HEALTH DEPT. APR 18 1972		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.	
25C. FUNERAL DIRECTOR MEDICAL EXAMINERS OFFICE		ADDRESS	

SW 1/4 S.

MIAMI CO. IOWA

\$1.00

ADDITIONAL INFORMATION

CHANCE FOR THE YEAR 1900

[Handwritten signature]

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. <u>72 03743</u>
1. NAME OF DECEASED (Type or Print) <u>BABY GIRL MACKIN</u>		2. DATE AND HOUR OF DEATH <u>MARCH 24, 1972</u> <u>1:00 P</u> M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>5 CHURCH HOME AND HOSPITAL</u>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>BALTO</u> C. CITY OR TOWN <u>OWING MILLS</u> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER <u>12 RICH MAR CT.</u>		
5. SEX <u>F</u>	6. RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MARCH 24, 1972</u>	9. AGE (In years lost birthday) <u>NB</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>
13. FATHER'S NAME <u>MILES J. MACKIN</u>		14. MOTHER'S MAIDEN NAME <u>YOLANDA KWARD</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <u>IMMATURITY</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>YES</u>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from <u>MARCH 24</u> 19 <u>72</u> to <u>MARCH</u> 19 <u>72</u> that (I) (we) last saw the deceased alive on <u>19</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <u>Humberto G. Hernandez, M.D.</u>		23B. DATE SIGNED <u>March 24, 1972</u>		23C. PHYSICIAN'S NAME (Type) <u>HUMBERTO G. HERNANDEZ, M.D.</u>
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <u>3-28-72</u>		24C. NAME OF CEMETERY or CREMATION (City or county) (State) <u>CHURCH HOME & HOSPITAL</u>
25A. DATE REC'D BY HEALTH DEPT. <u>APR 19 1972</u>		25B. NAME OF REGISTRAR <u>John E. Jones, M.D.</u>		

ANATOMY BOARD OF MARYLAND
JOHNS HOPKINS MEDICAL SCHOOL
MORTUARY SERVICE - ROOM



CERTIFICATE OF DEATH

REG. NO.

72 03744

72 03744

BIRTH NO.

1. NAME OF DECEASED

(Type or Print)

ZARRIELLO, Paul Charles

2. DATE AND HOUR OF DEATH

April 17, 1972

7:10 P.

M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

U.S. PHS HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE

Maryland

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒NO ☐

E. STREET AND NUMBER

2910 Cresmont Avenue

5. SEX

Male

6. RACE

White

7. MARRIED ☒NEVER MARRIED ☐WIDOWED ☐DIVORCED ☐

8. DATE OF BIRTH

7-16-1907

9. AGE (In years
last birthday)

64

If Under 1 Yr.
Months DaysIf Under 24 Hrs.
Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Wood finisher

10B. KIND OF BUSINESS OR INDUSTRY

Asst. Superintendent
Carpenter

11. BIRTHPLACE (State or foreign country)

Italy

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Joseph Zarriello

14. MOTHER'S MAIDEN NAME

Fannie ~~(deceased prior to marriage)~~ Olivetti

15. Was Deceased Ever in U. S. Armed Forces?

(Yes, no or unknown) (If yes, give war or dates of service)

NO

--

16. SOCIAL
SECURITY NO.

213 01 6264

17. INFORMANT

ADDRESS

MED. REC. US PHS HOSPITAL, Balto., Md

18.

209 X I

CAUSE OF DEATH

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

Acute bronchopneumonia & pyelo-

(A) IMMEDIATE CAUSE nephritis
DUE TO, OR AS A CONSEQUENCE OF:

days

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.

(B) Generalized myeloid metaplasia

DUE TO, OR AS A CONSEQUENCE OF:

weeks

(C) myelofibrosis

weeks

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART I (A).

Massive ascites

days

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

2

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

YES

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

YES

21A. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID
INJURY OCCUR?
(If in Baltimore City, give exact location)21D. TIME
OF INJURY
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At
Work ☐Not While
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from March 24 19 72 to April 17 19 72

that (I) (we) last saw the deceased alive on April 17 19 72 and that in (my) (our) opinion death occurred on the date

and hour and from the causes stated above. (I) (We) (did) (not) view the body after death.

23A. SIGNATURE

Vija L. Bauer, M.D.

Attending
Phys. ☐Med.
Director ☐Staff
Phys. ☒

23B. DATE SIGNED

4-18-72

23C. PHYSICIAN'S
NAME (Type)

Vija L. Bauer, M.D.

23D. ADDRESS

3100 Wyman Pk. Dr., Balto., Md. 21211

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

4/21/72

24C. NAME of CEMETERY or CREMATORY

Moreland Memorial Park

24D. LOCATION

Baltimore Maryland

25A. DATE REC'D BY HEALTH DEPT.

APR 19 1972

25B. NAME OF REGISTRAR

Robert L. ...

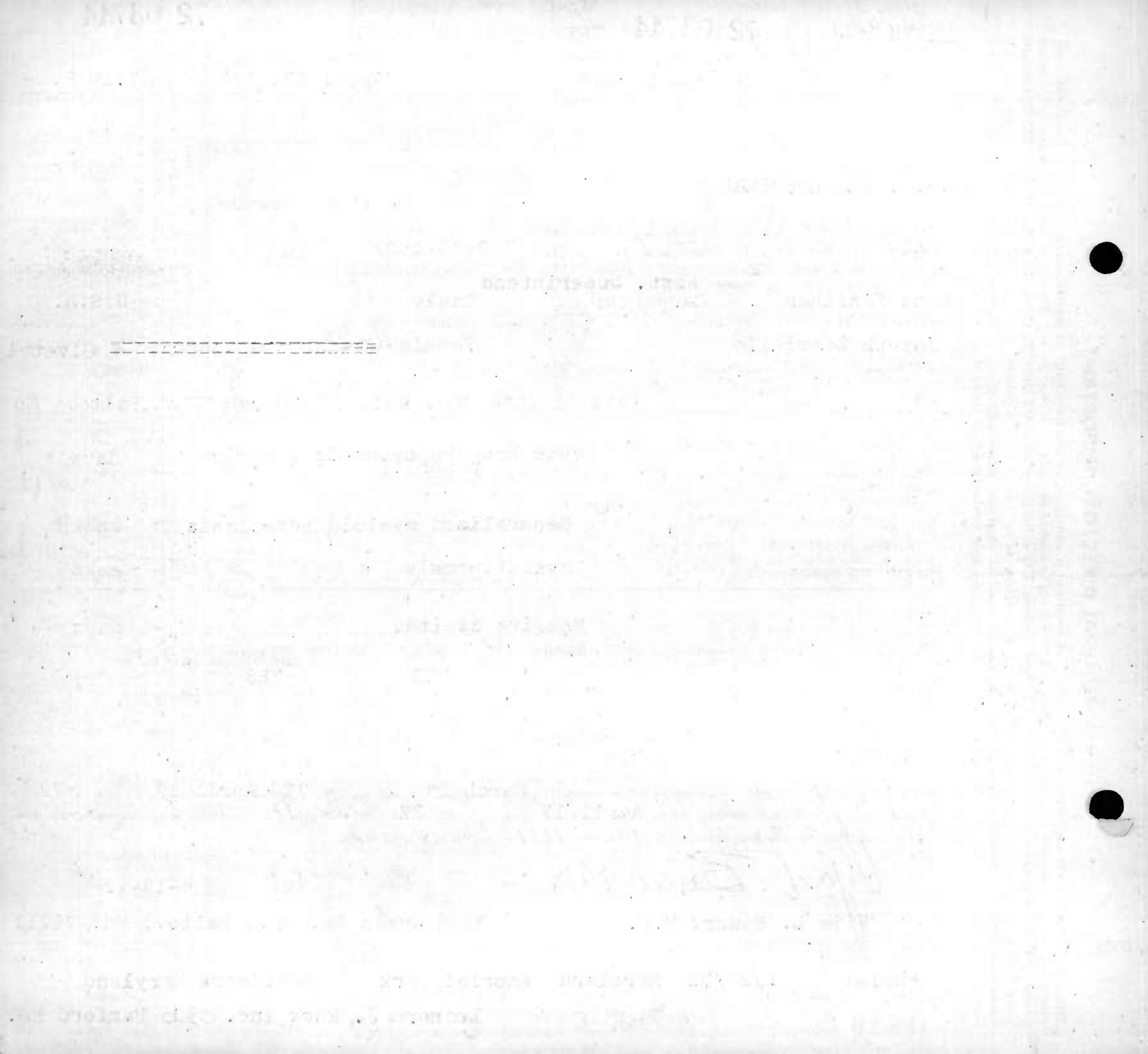
25C. FUNERAL DIRECTOR

Leonard J. Ruck Inc. 5305 Harford Rd.

ADDRESS

FUNERAL DIRECTOR: IMPORTANT

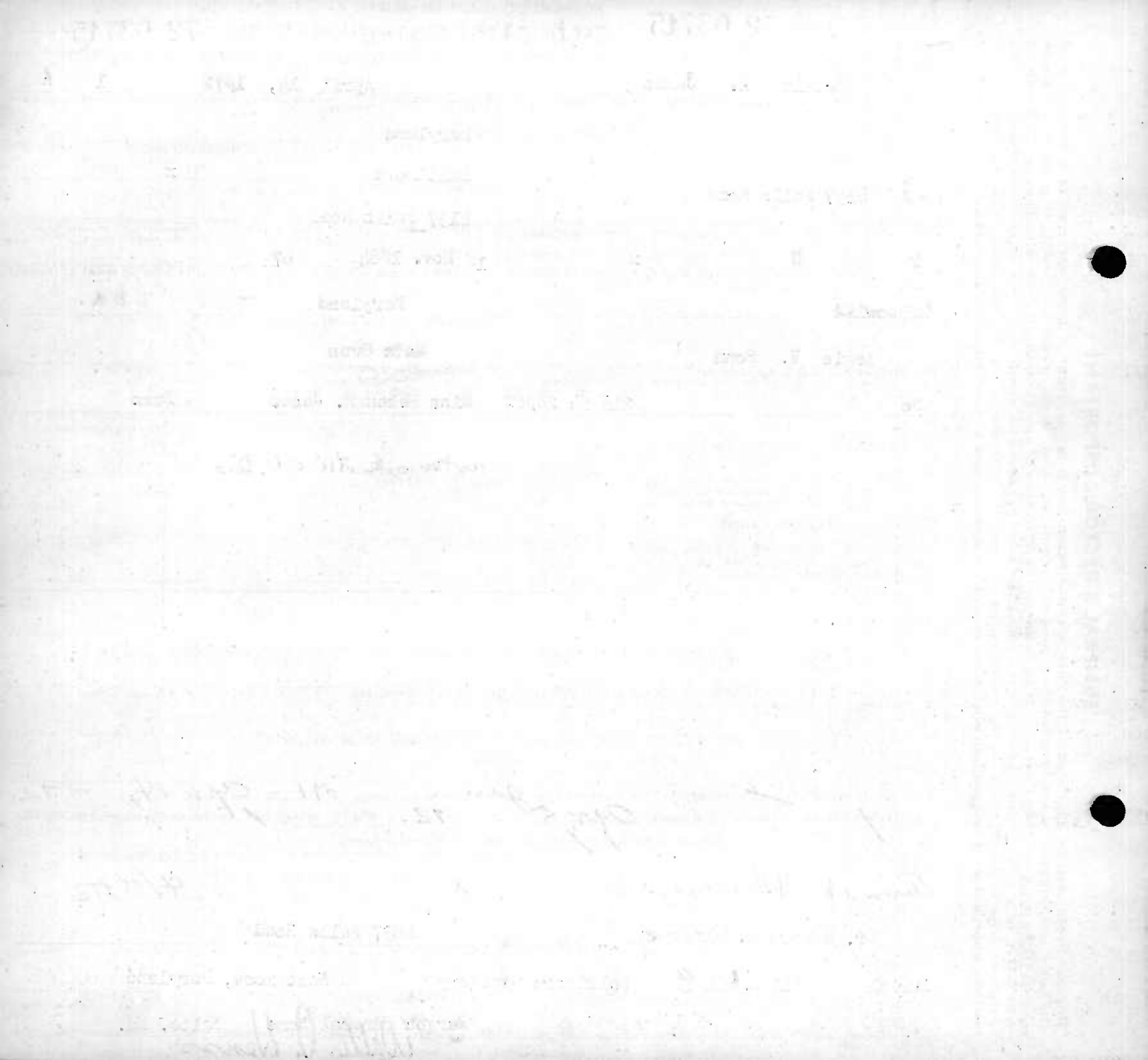
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72-03745	
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
Lottie A. James		April 14, 1972		1 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			A. STATE B. COUNTY		
00 4137 Falls Road			Maryland		
			C. CITY OR TOWN		D. INSIDE CITY LIMITS?
			Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
5. SEX			6. RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
F			W		WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)
Housewife					Maryland
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
Lewis V. Bonn			Kate Owen		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT
No			215 54 2896T		Miss Helen R. James
18. 412.4 I			CAUSE OF DEATH		ADDRESS
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH			(A) IMMEDIATE CAUSE, ENTERED AS CAUSE OF DEATH, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)			interlock tic cu Dis.		
ANTECEDENT CAUSES			(B) DUE TO, OR AS A CONSEQUENCE OF:		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(C) DUE TO, OR AS A CONSEQUENCE OF:		
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
(Month) (Day) (Year) (Hour)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from Jan 1971 to Apr 14, 1972, that (I) (we) last saw the deceased alive on Apr 5, 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
Dr. Edward L. Glassman				4/15/72	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
Dr. Edward L. Glassman				4037 Falls Road	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY	
Burial		17 April 72		Baltimore Cemetery	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
APR 19 1972		Robert E. Jackson, Jr.		Burgess Funeral Home	
				Balto. Md.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

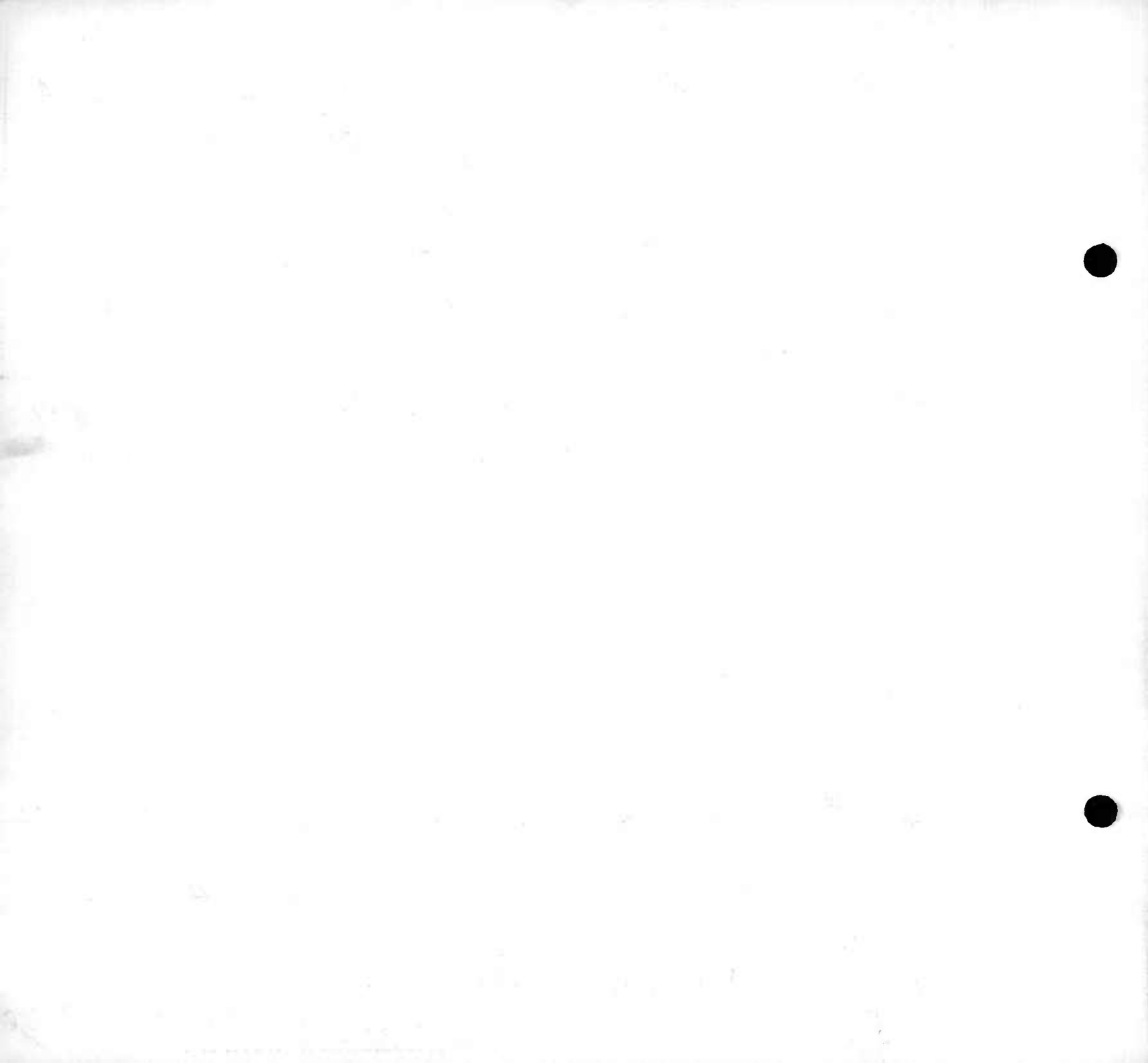
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 03746	
T-500 72 03746 BIRTH NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) Elizabeth D. Towne			2. DATE AND HOUR OF DEATH April 16, 1972 4:00 PM		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY		
FULL NAME OF HOSPITAL OR INSTITUTION 90 The Wesley Home 2211 West Rogers Avenue			C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
5. SEX Female 6. RACE White 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH Jan 16 1880 9. AGE (In years last birthday) 92		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			11. BIRTHPLACE (State or foreign country) New Jersey		
10B. KIND OF BUSINESS OR INDUSTRY -			12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Elias Day			14. MOTHER'S MAIDEN NAME Melissa Green		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO. 215 09 0495D		
17. INFORMANT The Wesley Home 2211 W Rogers Ave 21209			ADDRESS		
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). 19A. DATE OF OPERATION 0 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Cerebral arteriosclerosis 20A. AUTOPSY? (Yes or No) No 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from 9 July 19 69 to 16 April 19 72, that (I) (we) last saw the deceased alive on 16 April 19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE John W. Barnaby			23B. DATE SIGNED 18 Apr 72		
23C. PHYSICIAN'S NAME (Type) Dr. John W. Barnaby			23D. ADDRESS 1652 E. Belvedere Avenue		
24A. BURIAL CREMATION, REMOVAL (Specify) Cremation		24B. DATE 4-20-72		24C. NAME of CEMETERY or CREMATORY Greenmount Crematory	
24D. LOCATION Baltimore Maryland		24E. (City, town, or county)		24F. (State)	
25A. DATE REC'D BY HEALTH DEPT. APR 19 1972		25B. NAME OF REGISTRAR Robert E. Barnaby		25C. FUNERAL DIRECTOR Surgee Funeral Home Balto. Maryland	
25D. ADDRESS		25E. ADDRESS		25F. ADDRESS	

1960 - Adm. to N.H.
OT

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

P-620 72 03747		BALTIMORE CITY HEALTH DEPARTMENT		72 03747	
BIRTH NO.		CERTIFICATE OF DEATH		REG. NO.	
1. NAME OF DECEASED (Type or Print) PIERCE, FRANCES L.		2. DATE AND HOUR OF DEATH 4-16-72 1:15 A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) SINAI HOSPITAL		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MD. 8. COUNTY BALTIMORE C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 84 YORKWAY 21222			
5. SEX F	6. RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-11-18	9. AGE (In years last birthday) 54	10. Under 1 Yr. Months Days 11 Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10B. KIND OF BUSINESS OR INDUSTRY NONE		11. BIRTHPLACE (State or foreign country) N. CAROLINA	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Joseph Lee		14. MOTHER'S MAIDEN NAME Julia Howard	
15. Was Deceased Ever In U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 231 18 6829		17. INFORMANT JUNIUS W PIERCE 84 YORKWAY	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH CARCINOMA OF THE CERVIX (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 15 MO.	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 19A. DATE OF OPERATION 11/71, 1/71, 7/71		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED CA. OF CERVIX		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner) NO		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR	
22. I certify that (this hospital) attended the deceased from 4-3 19 72 to 4-16 19 72 that (we) last saw the deceased alive on 4-16-72 19 72 and that (we) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (did) view the body after death.					
23A. SIGNATURE Ronald P. Byank, M.D. 1906		23B. DATE SIGNED 4-16-72		23C. PHYSICIAN'S NAME (Type) R. P. BYANK M.D.	
23D. ADDRESS SINAI HOSPITAL		24. BURIAL CREMATION, REMOVAL (Specify) BURIAL			
24B. DATE April 18, 1972		24C. NAME OF CEMETERY OR CREMATORY GREENWOOD		24D. LOCATION (City, town, or county) (State) TARBORA, Edgecomb N.C.	
25A. DATE REC'D BY HEALTH DEPT. APR 19 1972		25B. NAME OF REGISTRAR J. J. J. J.		25C. FUNERAL DIRECTOR BORGEE FUNERAL HOME 3631 FALLS R.	



N-620

72 03748

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO. 72 03748

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Norris, James

2. DATE AND HOUR OF DEATH

April 13, 1972 8:00 A. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

Baltimore City Hospitals

4940 Eastern Avenue

Baltimore, Maryland

21224

4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)

A. STATE Maryland

C. CITY OR TOWN Baltimore

D. INSIDE CITY LIMITS?

YES ☒NO ☐

E. STREET AND NUMBER

320 Tula Street 21224

5. SEX

Male

6. RACE

Caucasian

7. MARRIED ☒ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH

Sep 20 1919

9. AGE (in years last birthday)

52

If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Operator Eng.

10B. KIND OF BUSINESS OR INDUSTRY

C J. Langenfelter

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Charles Norris

14. MOTHER'S MAIDEN NAME

Sadie Ridgell

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL SECURITY NO.

216 18 3987

17. INFORMANT

4940 Eastern Avenue

ADDRESS

BCH: RECORDS Baltimore, Maryland 21224

18. 747.81

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(A) IMMEDIATE CAUSE RESPIRATORY ARREST
DUE TO, OR AS A CONSEQUENCE OF:

SUDDEN.

(B) C.V.A. - @ INTRACEREBRAL HEMATOMA 5 DAYS.
DUE TO, OR AS A CONSEQUENCE OF:

(C) CEREBROVASCULAR MALFORMATION.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).

BRONCHIAL ASTMA - HYPERT DISEASE 10 YEARS.

19A. DATE OF OPERATION

3 4/8/72

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

INTRACEREBRAL HEMATOMA

20A. AUTOPSY? (Yes or No)

YES

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

BRAIN DAMAGE.

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)

NO

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)

21E. INJURY OCCURRED

While At Work ☐Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 4/8 1972 to 4/13 1972 that (I) (we) last saw the deceased alive on 4/13/72 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

D. Concha.

DEGREE

Attending Phys. ☐Med. Director ☐Staff Phys. ☒

23B. DATE SIGNED

4/13/72

23C. PHYSICIAN'S NAME (Type)

DR. SELIM CONCHA

DEGREE

23D. ADDRESS

6046 EAST PRATT ST. BALT. MD 21224

24A. BURIAL CREMATION, REMOVAL (Specify)

Burial

24B. DATE

4-17-72

24C. NAME OF CEMETERY OR CREMATORY

Oak Lawn Cemetery

24D. LOCATION (City, town, or county) (State)

Baltimore, Maryland

25A. DATE REC'D BY HEALTH DEPT.

APR 19 1972

25B. NAME OF REGISTRAR

R. E. Fisher, MD

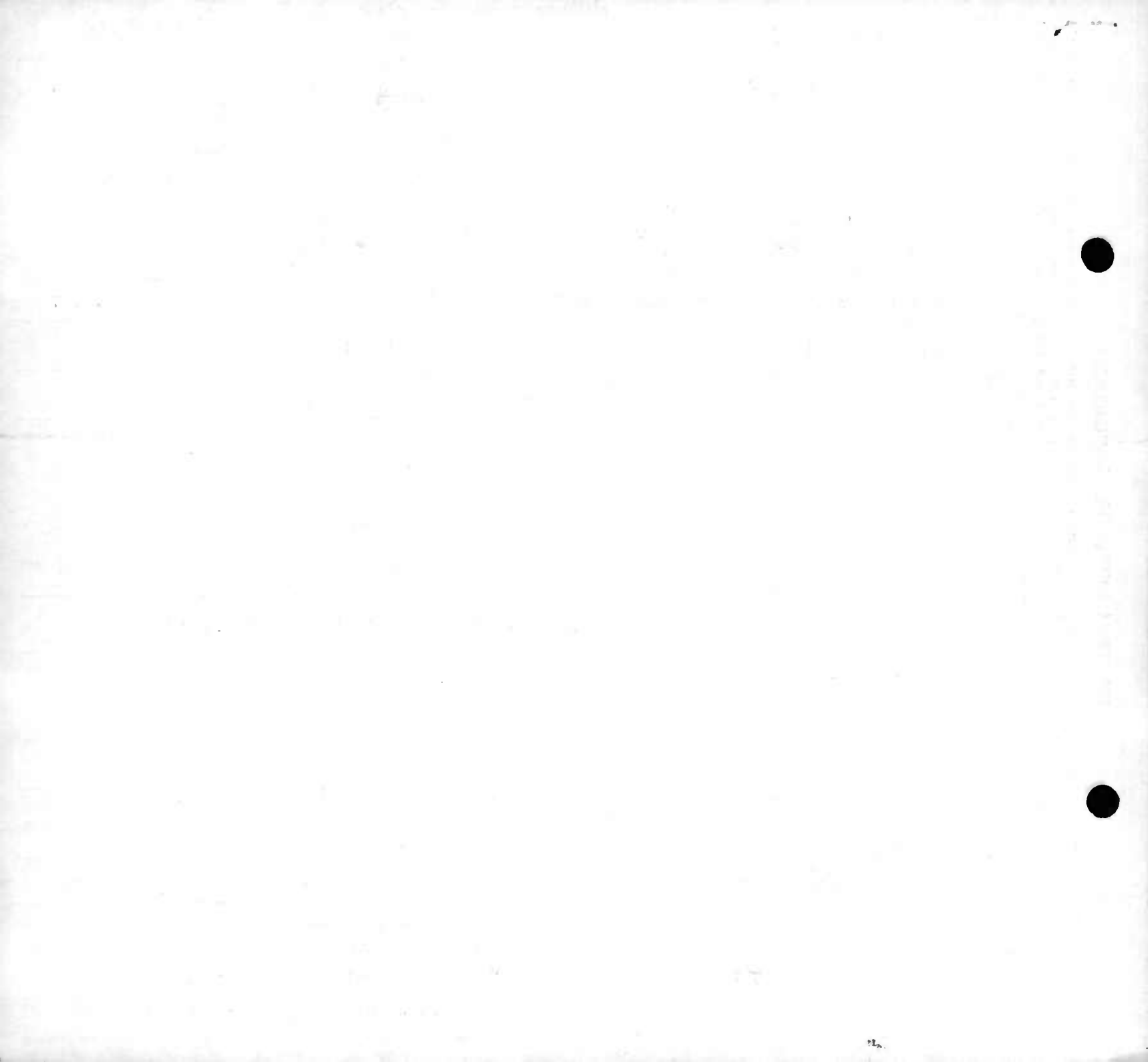
25C. FUNERAL DIRECTOR

WALTER DADROWSKI 1005 DUNDALK AVENUE

ADDRESS

FUNERAL DIRECTOR: IMPORTANT

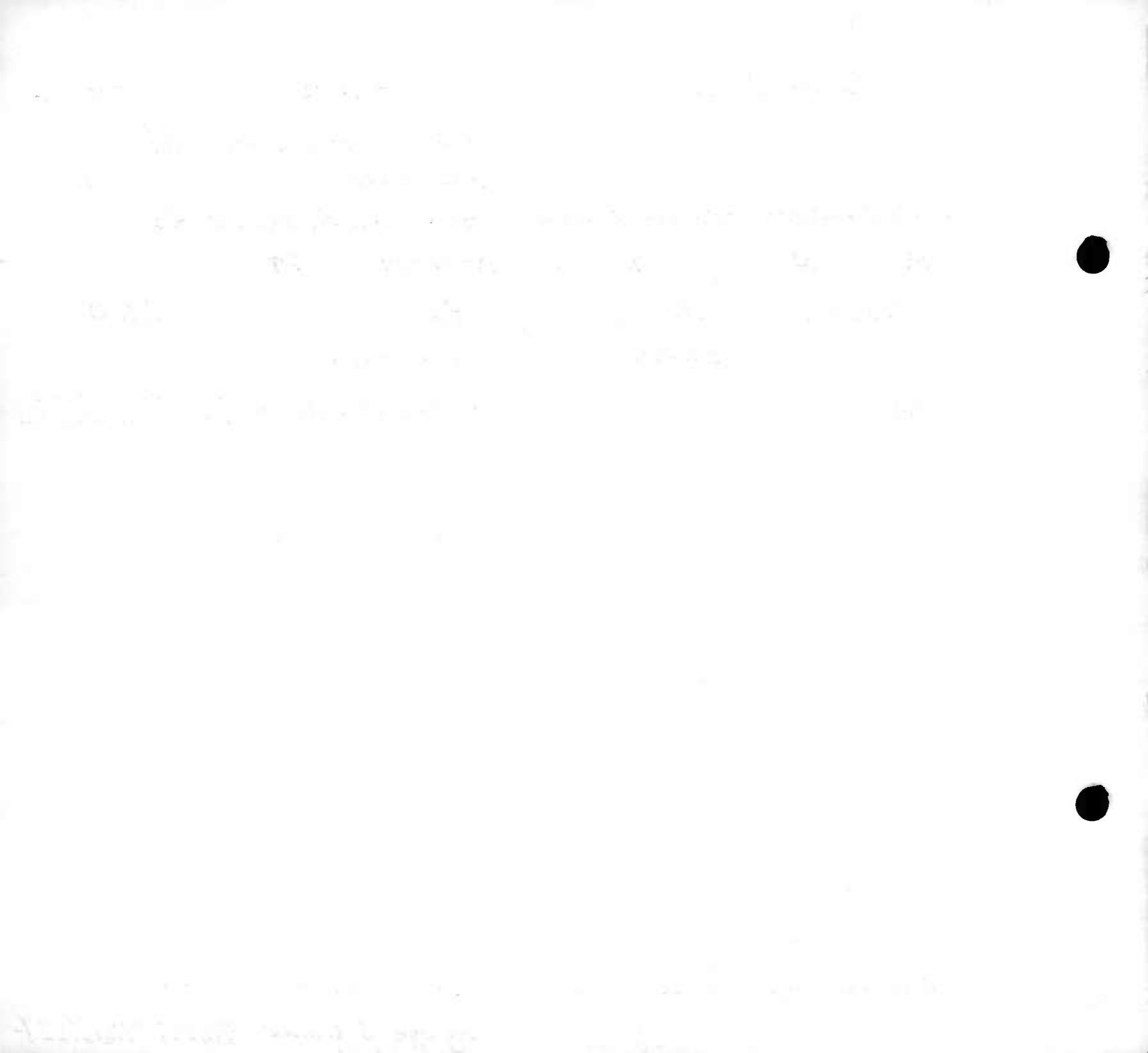
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

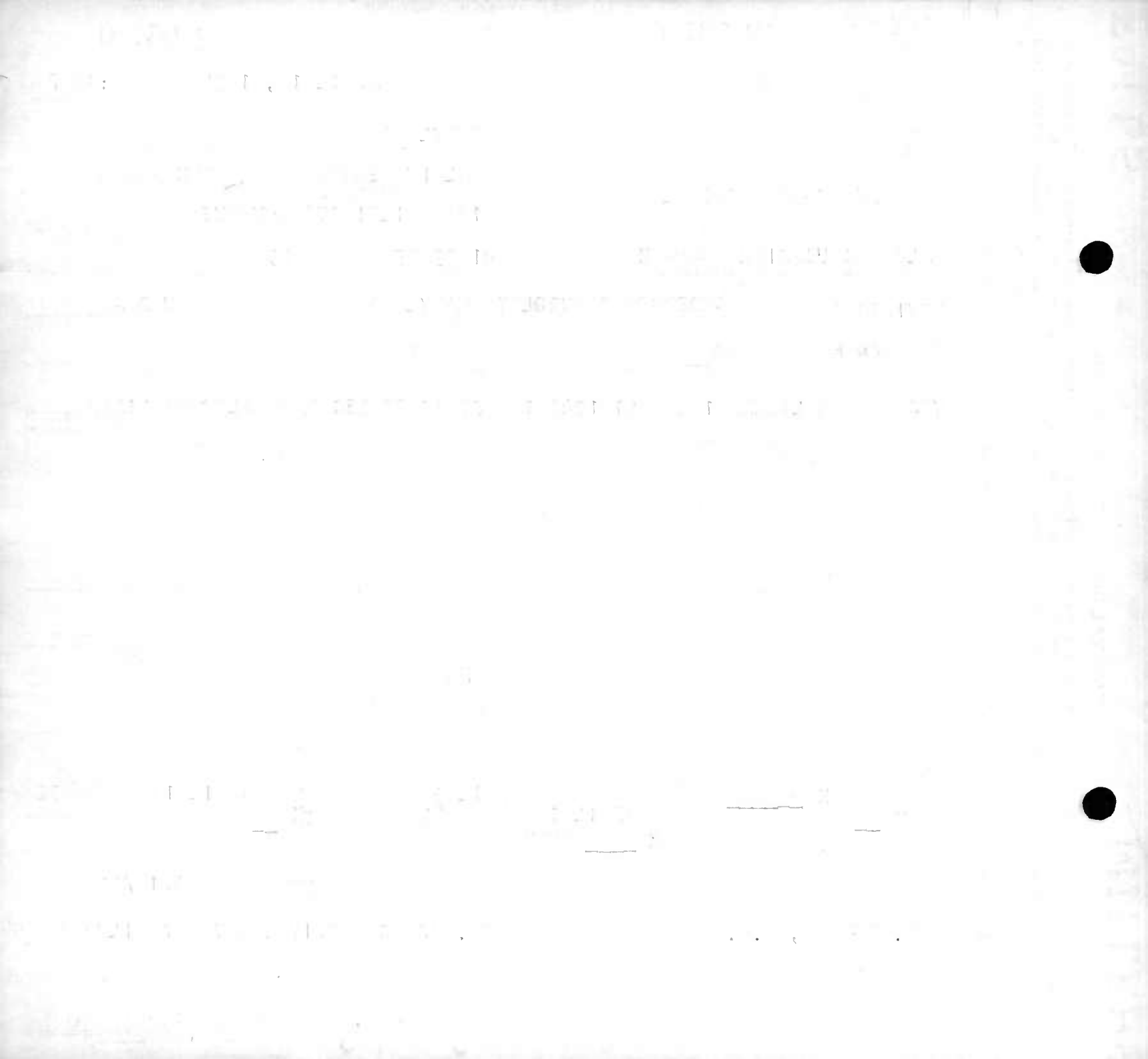
BALTIMORE CITY HEALTH DEPARTMENT				72 03749	
B-420				72 03749	
CERTIFICATE OF DEATH				REG. NO.	
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
ORLEY L. BLACK		4-16-72 5:10 A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION 43 SOUTH BALTIMORE GENERAL HOSPITAL		A. STATE MA B. COUNTY Anne Arundel 5200			
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX M		6. RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		8. DATE OF BIRTH 11-16-04	
Welder		BALTIMORE City		9. AGE (In years last birthday) 67	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		11. BIRTHPLACE (State or foreign country)	
BLACK		Unknown		PA	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		12. CITIZEN OF WHAT COUNTRY?	
No		201-07-0053A		U.S.A.	
17. INFORMANT		ADDRESS			
MR Robert C. Black		120 Irene Road Glen Burnie, Md			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH			
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE CARCINOMA OF THE LUNG			
ANTECEDENT CAUSES		DUE TO, OR AS A CONSEQUENCE OF:			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) CARCINOMA METASTATIC OF LIVER			
		(C) ATHEROSCLEROSIS CARDIOVASCULAR DISEASE			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
				YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
				NO	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
(Month) (Day) (Year) (Hour)		White At <input type="checkbox"/> Not White At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from 4-6-72 to 4-16-72 that (I) (we) last saw the deceased alive on 4-16-72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Edith H. Dalgo				23B. DATE SIGNED 4-16-72	
23C. PHYSICIAN'S NAME (Type) EDITH H. DALGO				23D. ADDRESS SOUTH BALTIMORE GENERAL HOSPITAL	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY	
BURIAL		4/19/72		CEDAR HILL CEMETERY	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
APR 10 1972		R. E. S. [Signature]		George J. Gonce	
				ADDRESS 400 Ritchie Hwy Baltimore, Md 21223	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>72 03750</u>	
G-353 <u>72 03750</u>		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <u>EDWARD S GOODHAND</u>			2. DATE AND HOUR OF DEATH <u>APRIL 16, 1972</u> <u>5:30 P.M.</u>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <u>40 ST AGNES HOSPITAL</u> IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION			4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>2582</u> C. CITY OR TOWN <u>BALTIMORE</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>1089 WILMINGTON AVENUE</u>		
5. SEX <u>MALE</u>	6. RACE <u>CAUCASIAN</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>01 09 95</u>	9. AGE (In years last birthday) <u>77</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED Shop Foreman</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>ANDERSON CHEVROLET</u>	11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>
13. FATHER'S NAME <u>James Goodhand</u>			14. MOTHER'S MAIDEN NAME <u>Unknown</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>YES</u> <u>WORLD WAR 1</u>		16. SOCIAL SECURITY NO. <u>215104901</u>	17. INFORMANT <u>ST AGNES RECORDS BALTO MD 21229</u>		
18. <u>492X</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>Respiratory arrest</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last, <u>Ephysema.</u>			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>NO</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>APRIL 3</u> 19 <u>72</u> to <u>APRIL 16</u> 19 <u>72</u> that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>APRIL 16</u> 19 <u>72</u> and that <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) (did) not view the body after death.					
23A. SIGNATURE <u>E. Romero M.D.</u> DEGREE				23B. DATE SIGNED <u>4/16/72</u>	
23C. PHYSICIAN'S NAME (Type) <u>E. ROMERO, M.D.</u> DEGREE		23D. ADDRESS <u>ST. AGNES HOSPITAL CATON & WILKENS AVE</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>	24B. DATE <u>4/19/72</u>	24C. NAME of CEMETERY or CREMATORY <u>Woodlawn Cemetery</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore</u> <u>Maryland</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>APR 19 1972</u>		25B. NAME OF REGISTRAR <u>George J. Gonce</u>		25C. FUNERAL DIRECTOR ADDRESS <u>4001 Fitchie Hwy Balto, Md 21225</u>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

L-600		72 03751		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 1329 72 03751	
BIRTH NO.				1. NAME OF DECEASED (Type or Print) LORY, EDWARD G.			
2. DATE AND HOUR OF DEATH 4/16/72				16 ³⁰ A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY 2544			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) CERTIFICATE AMENDED HARBOR VIEW NURSING CENTER 4-21-72				C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER 4213 XXXXX STXX				4102 Townsend Ave			
5. SEX MALE	6. RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/22/07	9. AGE (In years last birthday) 64	If Under 1 Yr. Months: Days: Hours: Min.		If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NEVER WORKED		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William LORY				14. MOTHER'S MAIDEN NAME Lilliane MORAN Lillian Moran			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give year or dates of service) UNKNOWN (No)		16. SOCIAL SECURITY NO. 218056495		17. INFORMANT Mrs Elizabeth Lory Balto, Md 21225			
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Carcinoma, Lung, Right ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Generalized Metastasis				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 months			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 4-14-72 to 4-16-72 that (I) (we) last saw the deceased alive on 4-16-72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Roberto V. Gonce, M.D.				23B. DATE SIGNED 4-16-72		23C. PHYSICIAN'S NAME (Type)	
23D. ADDRESS				DEGREE			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4/19/72		24C. NAME OF CEMETERY OR CREMATORY New Cathedral Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. APR 19 1972		25B. NAME OF REGISTRAR George J. Gonce		25C. FUNERAL DIRECTOR George J. Gonce		ADDRESS 4001 Ritchie Hwy Balto, Md 21225	

4-21-1972 - Letter from Harbor View Nursing & Convalescent Center - Mary Ann Schell, R.N.,
1213 Light Street, Balto., Md.

&

Certification by Funeral Director - George J. Gonce.

HRS

1. NAME OF DECEASED (Type or Print)		2. DATE OF DEATH		3. DATE PRONOUNCED DEAD		4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FRANK MADL		Known <input type="checkbox"/> Estimated <input type="checkbox"/>		Month Day Year Hour April 15, 1972 9:50 A.		FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 3713 Mt. Pleasant Avenue		A. STATE Maryland B. COUNTY 2608	
6. SEX Male		7. RACE White		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
9. DATE OF BIRTH 9/11/93		10. AGE (In years lost birthday) 78		11. BIRTHPLACE (State or foreign country) GERMANY		12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME LUDWIG MADL	
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		14B. KIND OF BUSINESS OR INDUSTRY STEEL		15. MOTHER'S MAIDEN NAME KATHERINE MAUSMILLER		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) UNK		17. SOCIAL SECURITY NO. 216-104631	
18. INFORMANT ADDRESS MILTON HALL 9731 BIRD RIVER RD		19. CAUSE OF DEATH Gunshot wound of head		20. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) yes (head-only)	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Home (basement)		22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 3713 Mt. Pleasant Avenue 2608	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(B) DUE TO, OR AS A CONSEQUENCE OF:		22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.) 4-13-72 Unk. m.		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? Self-inflicted	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		(C)		23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 4/19/72	
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Ronald N. Kornblum, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>		ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 4/16/72	
24C. NAME OF CEMETERY OR CREMATORY 2101 LUTHERAN		24D. LOCATION (City, town, or county) (State) BALTO. MD.		25A. DATE REC'D BY HEALTH DEPT. APR 19 1972		25B. NAME OF REGISTRAR J.E. CONNELLY		25C. FUNERAL DIRECTOR ADDRESS 300 MACE	

72 03753 BALTIMORE CITY HEALTH DEPARTMENT				72 03753			
M-532				MEDICAL EXAMINER'S CERTIFICATE OF DEATH			
BIRTH NO. 69-01840				REG. NO.			
1. NAME OF DECEASED (Type or Print) Lanora Montague				2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month 4 Day 6 Year 72 Hour M.			
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 00 1908 N. Pulaski St.				3. DATE PRONOUNCED DEAD Month 4 Day 6 Year 72 Hour 6:45 p. M.			
5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY 1504							
6. SEX female		7. RACE Negro		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Balto.	
9. DATE OF BIRTH 1/26/69		10. AGE (In years last birthday) 3 years		11. BIRTHPLACE (State or foreign country) BALTO. Md.		E. STREET AND NUMBER 1908 N. Pulaski St.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME JAMES ROOTHs		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) INFANT		15. MOTHER'S MAIDEN NAME LAVERNE MONTAGUE	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) NO NONE		17. SOCIAL SECURITY NO. NONE		18. INFORMANT LAVERNE MONTAGUE-1908 N. PULASKI ST.		ADDRESS	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Blunt force injuries to head and trunk DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. ANTECEDENT CAUSES OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED				21. AUTOPSY? (Yes or No) yes	
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) HOME		22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 1908 N. Pulaski St. 1504			
22D. TIME OF INJURY (APPROX.) 4 6 72 unk.		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? Battered child			
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE: Peter Lipkovic, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) DATE SIGNED: 4/7/72 ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>							
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 4/17/72		24C. NAME OF CEMETERY or CREMATORY NEW CATHEDRAL		24D. LOCATION (City, town, or county) Old Frederick Rd. BALTO Md.	
25A. DATE REC'D BY HEALTH DEPT. APR 19 1972		25B. NAME OF REGISTRAR N 83778-2000		25C. FUNERAL DIRECTOR KRAUSE FUNERAL HOME		ADDRESS 1216 S. CHARLES ST	

SECRET

SECRET

SECRET



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. <u>72 03754</u>	
1. NAME OF DECEASED (Type or Print) <u>WALTER CLARK</u>		2. DATE AND HOUR OF DEATH <u>4-14-72</u> <u>2:30 A.M.</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>SINAI HOSPITAL OF BALTIMORE INC.</u>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore</u>			
5. SEX <u>M.</u> 6. RACE <u>Cauc.</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>6-14-1894</u>		9. AGE (In years last birthday) <u>77</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Guard</u>		11. BIRTHPLACE (State or foreign country) <u>New York</u>	
13. FATHER'S NAME <u>unknown</u>		14. MOTHER'S MAIDEN NAME <u>unknown</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u> Yes <u>W.W.1 & W.W.11</u>		16. SOCIAL SECURITY NO. <u>197039126-A</u>		17. INFORMANT <u>EVELYN BUTZ.</u>	
18. <u>413.41</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>CEREBRAL THROMBOSIS</u>		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>SEPTICEMIA</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>10 DAYS.</u>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>ASCUD. CHF.</u>		(B) DUE TO, OR AS A CONSEQUENCE OF: <u>2445.</u>			
(C) <u>2045.</u>					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>4-1-72</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>YES.</u>		20A. AUTOPSY? (Yes or No) <u>YES.</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>4-1</u> 19 <u>72</u> to <u>4-14</u> 19 <u>72</u> that (I) (we) last saw the deceased alive on <u>4-14</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>GUTIERREZ.</u>		23B. DATE SIGNED		23C. PHYSICIAN'S NAME (Type) <u>FELIX GUTIERREZ</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>CREMATION</u>		24B. DATE <u>4/17/1972</u>		24C. NAME OF CEMETERY or CREMATORY <u>Loudon Park Crematory</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>APR 19 1972</u>		25B. NAME OF REGISTRAR <u>[Signature]</u>		25C. FUNERAL DIRECTOR <u>Loring Byers</u>	
26A. ADDRESS <u>8728 Liberty Rd. Randallstown, Maryland 21133</u>		26B. ADDRESS <u>7117 Campfield Rd.</u>		26C. ADDRESS <u>7117 Campfield Rd.</u>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. W-500				BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 72 03755	
1. NAME OF DECEASED (Type or Print) RALPH C. WANN				2. DATE AND HOUR OF DEATH 4/16/72 8 20 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD UNIVERSITY HOSP				4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE BALTIMORE MD B. COUNTY 5300			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) UNIVERSITY HOSP				C. CITY OR TOWN		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER ROSEWOOD STATE HOSP			
5. SEX M	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12-8-44		9. AGE (In years last birthday) 27	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Md		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME WILLIAM WANN				14. MOTHER'S MAIDEN NAME MILDRED LESTER			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. NONE		17. INFORMANT University Hosp Info Sheet		ADDRESS	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, head injury, or complication which caused death.) Mediastinitis ANTECEDENT CAUSE 2° to Perforation Esophagus DISEASE OR CONDITION GIVING RISE TO THE ABOVE CAUSE (A) stating the UNDERLYING CONDITION last. Foreign body perforation esophagus (saffron Pan)				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 7 weeks			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). Mental Retardation							
19A. DATE OF OPERATION 2/23/72		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED perforation		20A. AUTOPST? (Yes or No) yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? no	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input checked="" type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Hospital		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) Rosewood State Hospital 5300			
21D. TIME OF INJURY (APPROX.) 2-23-72 ?		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? Swallowed open safety Pin			
22. I certify that (A) (this hospital) attended the deceased from 2/23/72 19 to 4/16/72 19 that (I) (was) last saw the deceased alive on 4/16/72 19 and that in (my) (was) opinion death occurred on the date and hour and from the causes stated above. (I) (did) (did not) view the body after death.							
23A. SIGNATURE Karl F. Meek, Jr. M.D.				23B. DATE SIGNED 4/16/72		23C. PHYSICIAN'S NAME (Type) KARL F. MECK, JR. M.D.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4/18/72		24C. NAME OF CEMETERY OR CREMATORY Moreland Memorial Park		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. APR 19 1972		25B. NAME OF REGISTRAR Raymond C. Fink		25C. FUNERAL DIRECTOR Raymond C. Fink		ADDRESS Glen Burnie, Md.	

Adm. 6/19/50

OT

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

S-162 72 03756				BALTIMORE CITY HEALTH DEPARTMENT		72 03756	
CERTIFICATE OF DEATH				REG. NO.			
1. NAME OF DECEASED (Type or Print) INGA F. SOBERG				2. DATE AND HOUR OF DEATH 4/17/72 6:50 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION UNION MEMORIAL HOSPITAL 44				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY 2702 C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 2704 GRINDON AVENUE			
5. SEX FEMALE	6. RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7/10/83	9. AGE (In years last birthday) 88	If Under 1 Yr. Months Days	If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10B. KIND OF BUSINESS OR INDUSTRY AT Home		11. BIRTHPLACE (State or foreign country) NORWAY		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME JOHAN JOHANSEN				14. MOTHER'S MAIDEN NAME CHRISTINE KRISTOFFERSEN			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO.		17. INFORMANT Henry J. Soberg		ADDRESS Same	
18. 199.1 + 1250.9 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: GASTRO INTESTINAL BLEEDING (B) PROBABLY MALIGNANCY (C) DIABETES MELLITUS, OLEMI				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 4/16/72 19 to 4/17/72 19, that (I) (we) last saw the deceased alive on 4/17/72 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE W. Delaney						23B. DATE SIGNED 4/17/72	
23C. PHYSICIAN'S NAME (Type) RATON SEE POSTED		23D. ADDRESS UNION MEMORIAL HOSPITAL					
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 4/20/72		24C. NAME OF CEMETERY OR CREMATORY Parkwood		24D. LOCATION (City, town, or county) (State) BALTIMORE MD	
25A. DATE REC'D BY HEALTH DEPT. APR 19 1972		25B. NAME OF REGISTRAR John E. Jones, M.D.		25C. FUNERAL DIRECTOR Chas. E. Evans		ADDRESS 8802 Harford Rd	

GENERAL HOSPITAL
FRENCH WARD

RECEIVED
JAN 10 1918

RECEIVED
JAN 10 1918

RECEIVED
JAN 10 1918

RECEIVED

JAN 10 1918

FUNERAL DIRECTOR: IMPORTANT

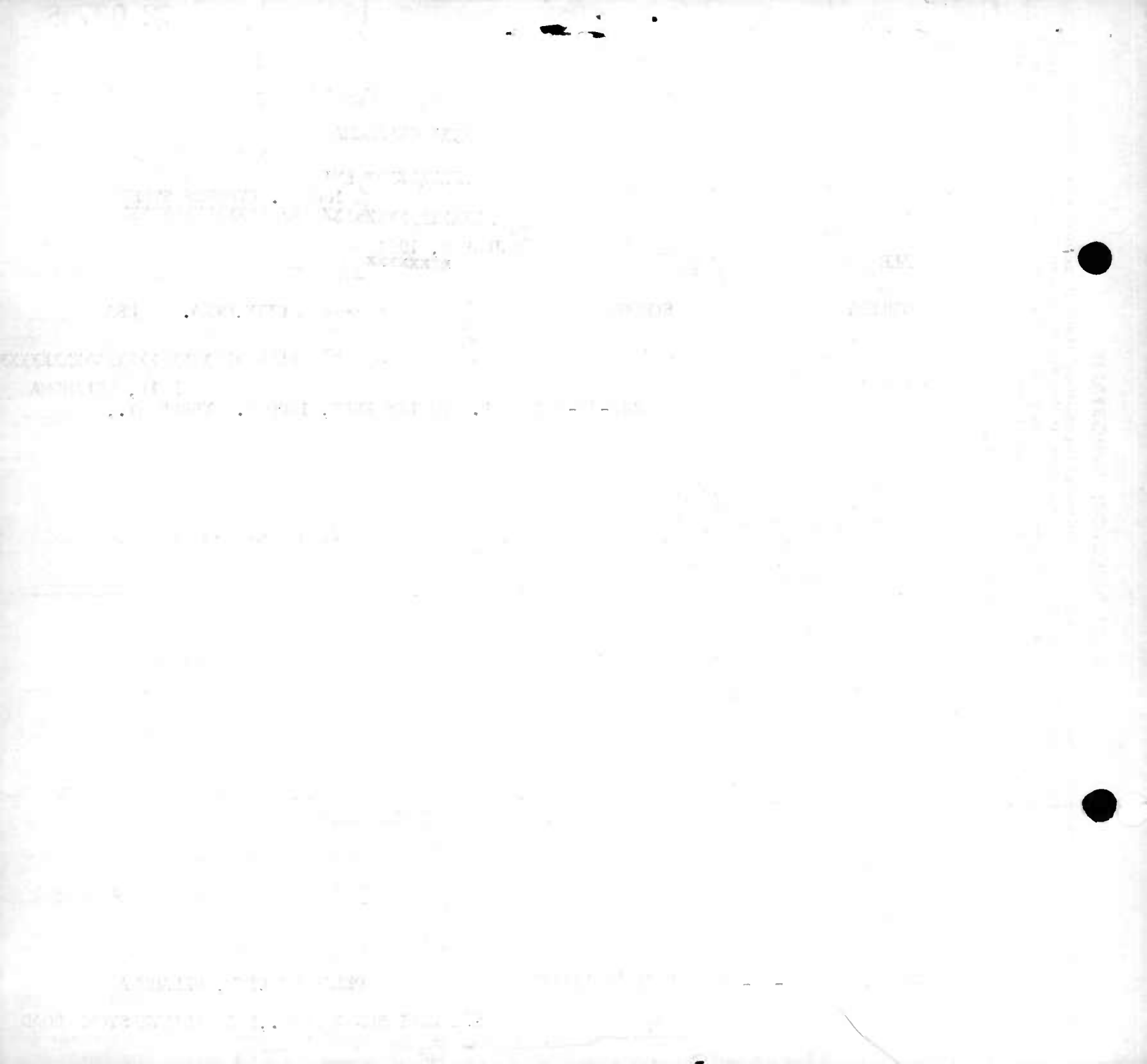
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT										REG. NO. 72 03757	
BIRTH NO. <u>D-325</u>										72 03757	
1. NAME OF DECEASED (Type or Print) <u>Walter Kennedy Dotson</u>					2. DATE AND HOUR OF DEATH <u>April 13, 1972</u> <u>11:25</u> P. M.						
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>US Public Health Service Hospital</u> <u>3100 Wyman Parkway</u>					4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>W. Va.</u> B. COUNTY <u>V 45</u>						
					C. CITY OR TOWN <u>Keystone</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
					E. STREET AND NUMBER <u>Box 558</u>						
5. SEX <u>M</u>		6. RACE <u>Caucasian</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>5/30/10</u>		9. AGE (In years last birthday) <u>61</u>		If Under 1 Yr. Months: Days: Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>				10B. KIND OF BUSINESS OR INDUSTRY <u>Coal Miner</u>		11. BIRTHPLACE (State or foreign country) <u>Va.</u>			12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
13. FATHER'S NAME <u>Walter Dotson</u>						14. MOTHER'S MAIDEN NAME <u>?</u>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>236-07-4611</u>		17. INFORMANT ADDRESS <u>Records- US PHS Hospital, Balto, Md!</u>					
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>Bronchopneumonia</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Acute myelomonocytic leukemia</u> II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>Anthracosilcosis of lungs</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Days</u> <u>Months</u> <u>Years</u>	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>yes</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>yes</u>					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)							
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?							
22. I certify that (I) (this hospital) attended the deceased from <u>Mar. 12</u> 19 <u>72</u> to <u>Apr. 13</u> 19 <u>72</u> , that (I) (we) last saw the deceased alive on <u>Apr. 13</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.											
23A. SIGNATURE <u>Arthur B. Abt, M.D.</u> DEGREE								Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>4/14/72</u> RGB	
23C. PHYSICIAN'S NAME (Type) <u>Arthur B. Abt, Surgeon</u> DEGREE				23D. ADDRESS <u>US PHS Hospital, Balto, Md. 21211</u>							
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>4/17/72</u>		24C. NAME of CEMETERY or CREMATORY <u>Grandview Memorial Gardens</u>			24D. LOCATION (City, town, or county) (State) <u>Bluefield, Virginia</u>				
25A. DATE REC'D BY HEALTH DEPT. <u>APR 19 1972</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor, M.D.</u>		25C. FUNERAL DIRECTOR <u>William E. Johnson</u>				ADDRESS <u>8521 Loch Raven Blvd.</u>			

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				72 03758		72 03758	
K-100				72 03758		72 03758	
1. NAME OF DECEASED (Type or Print) Marvin Kopp				2. DATE AND HOUR OF DEATH 4/14/72 4:20 M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE OKLAHOMA B. COUNTY V33			
FULL NAME OF HOSPITAL OR INSTITUTION Union Memorial Hosp.		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN ENID		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX MALE		6. RACE Caucasian		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH JUNE 8, 1951	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) STUDENT		10B. KIND OF BUSINESS OR INDUSTRY SCHOOL		9. AGE (In years last birthday) 20		11. BIRTHPLACE (State or foreign country) OKLAHOMA CITY, OKLA.	
13. FATHER'S NAME Charles H. Kopp		14. MOTHER'S MAIDEN NAME Blanche BLUM		12. CITIZEN OF WHAT COUNTRY? USA		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No	
16. SOCIAL SECURITY NO. 443-48-1029		17. INFORMANT MR. CHARLES KOPP, 1609 E. CYPRUS ST.		18. CAUSE OF DEATH Cardiac arrest		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH Cardiac arrest				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Cardiac arrest			
CHIEF OR ASST. MEDICAL EXAMINER Dr. H. S. [Signature]				(B) 2nd & 3rd degree BURNS 78% DUE TO, OR AS A CONSEQUENCE OF:			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(C)			
II							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION April 12, 1972		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Burns		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indify medical examined)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) home		21C. WHERE DID INJURY OCCUR? 932 F 41st St. 901		(If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) March 5, 1972		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? During firing motor cycle, fuel tank was burned			
22. I certify that (I) (this hospital) attended the deceased from 3/5 19 72 to 4/14 19 72 and that (I) (we) last saw the deceased alive on 4/14 19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Yang Nae Lee M.D.				23B. DATE SIGNED April 12, 1972		23C. PHYSICIAN'S NAME (Type) Yang Nae Lee M.D.	
23D. ADDRESS Union Memorial Hospital				23E. DEGREE MD		23F. ADDRESS Union Memorial Hospital	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 4-16-72		24C. NAME OF CEMETERY or CREMATORY EMANUEL HEBREW		24D. LOCATION (City, town, or county) (State) OKLAHOMA CITY, OKLAHOMA	
25A. DATE REC'D BY HEALTH DEPT. APR 19 1972		25B. NAME OF REGISTRAR John E. Taylor, M.D.		25C. FUNERAL DIRECTOR SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD		25D. ADDRESS REISTERSTOWN ROAD	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				CERTIFICATE OF DEATH		REG. NO. 72 03759	
BIRTH NO. M-460 72 03759		1. NAME OF DECEASED (Type or Print) JAY JEFFERSON MILLER		2. DATE AND HOUR OF DEATH 14 APR 72 10:50 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) SINAI HOSPITAL OF BALTIMORE				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY BALTO C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER JEMICY FARM			
5. SEX MALE	6. RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-4-97	9. AGE (In years last birthday) 74	If Under 1 Yr. Months Days	If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CHAIRMAN OF BOARD		10B. KIND OF BUSINESS OR INDUSTRY INNER HARBOR BALTO. CITY		11. BIRTHPLACE (State or foreign country) BALTIMORE, MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME ABRAHAM F. MILLER				14. MOTHER'S MAIDEN NAME HELEN KAHN			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES W.W. I NAVY		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS MRS. JOSEPHA MILLER, JEMICY FARM, PIKESVILLE, MD			
18. 410.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Myocardial Infarction (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Arteriosclerosis (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH? (Indicate by checkmark) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from _____ 19____ to _____ 19____ that (I) (we) last saw the deceased alive on _____ 19____ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Jack Wexler MD				23B. DATE SIGNED 14 APR 72		23C. PHYSICIAN'S NAME (Type) JACK WEXLER	
23D. ADDRESS 22 W. COLD SPRING LANE				23E. FUNERAL DIRECTOR ADDRESS SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 4-16-72		24C. NAME OF CEMETERY or CREMATORY DRUID RIDGE		24D. LOCATION (City, town, or county) (State) PIKESVILLE, MARYLAND	
25A. DATE REC'D BY HEALTH DEPT. APR 19 1972		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR			

15-00000

15-00000

15-00000

15-00000

15-00000

15-00000

15-00000

15-00000

15-00000

15-00000

15-00000

15-00000

15-00000

15-00000

15-00000

15-00000

15-00000

15-00000

15-00000

15-00000

15-00000

15-00000

15-00000

15-00000

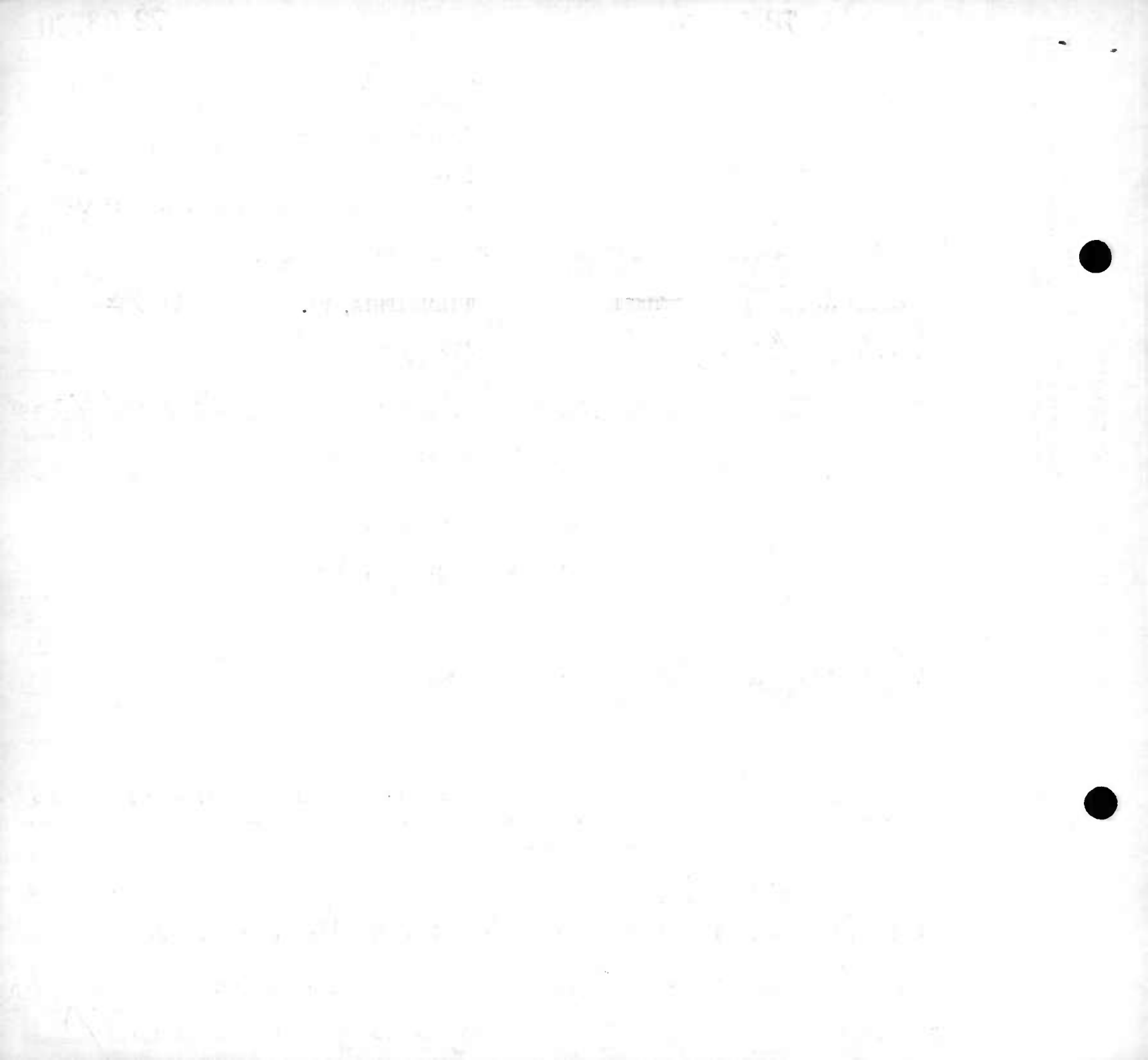
15-00000

15-00000

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Baltimore City Health Department CERTIFICATE OF DEATH				REG. NO. <u>72 03760</u>
1. NAME OF DECEASED (Type or Print) <u>MARCOVITZ, CELIA</u>		2. DATE AND HOUR OF DEATH <u>4-15-72</u> <u>8 A.</u> M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <u>SINAI HOSPITAL OF BALTIMORE INCORPORATED</u>		A. STATE <u>MARYLAND</u> B. COUNTY <u>BALTO</u>		
IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION		C. CITY OR TOWN <u>BALTIMORE</u>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
		E. STREET AND NUMBER <u>909 TEMPLECLIFF RD #8.</u>		
5. SEX <u>Female</u>	6. RACE <u>Caucasian</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-16-91</u>	9. AGE (In years last birthday) <u>80</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homemaker</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>AT HOME</u>		11. BIRTHPLACE (State or foreign country) <u>PHILADELPHIA, PA.</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Isadore Bergman</u>		
14. MOTHER'S MAIDEN NAME <u>Bessie</u>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		
16. SOCIAL SECURITY NO. <u>217-48-2572</u>		17. INFORMANT <u>Isadore Marcovitz-7522 Shelwood Rd 2/208</u>		
18. <u>540.01</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <u>PERITONITIS</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>3 weeks.</u>		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Acute Appendicitis</u>		(B) DUE TO, OR AS A CONSEQUENCE OF: <u>with perforation of appendix</u>		
II				
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				
19A. DATE OF OPERATION <u>4-2-1972</u>	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>ACUTE APPENDICITIS</u>	20A. AUTOPSY? (Yes or No) <u>No</u>	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?		
22. I certify that (H) (this hospital) attended the deceased from <u>3-31-1972</u> to <u>4-15-1972</u> that (I) we lost saw the deceased alive on <u>4-14-1972</u> and that in (my) our opinion death occurred on the date and hour and from the causes stated above. (I) We (did) did not view the body after death.				
23A. SIGNATURE <u>[Signature]</u>		23B. DATE SIGNED <u>4-15-72</u>		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>
23C. PHYSICIAN'S NAME (Type) <u>KRISHNAN, R. VARMA</u>		23D. ADDRESS <u>SINAI HOSPITAL, BALTO. MD.</u>		
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>	24B. DATE <u>4/16/72</u>	24C. NAME OF CEMETERY or CREMATORY <u>Har Sinai</u>	24D. LOCATION (City, town, or county) (State) <u>Eastman Ave, Baltimore, Md</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>APR 19 1972</u>	25B. NAME OF REGISTRAR <u>[Signature]</u>	25C. FUNERAL DIRECTOR <u>[Signature]</u> ADDRESS <u>6010 Reister Rd</u>		



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 72 03761

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Gilbert Kahan		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/>		Month 4	Day 14	Year 72	Hour M.
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION Sinai Hospital		3. DATE PRONOUNCED DEAD Month 4 Day 14 Year 72		Hour 8:05 a.		M.	
5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY 2720							
6. SEX male	7. RACE White	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Balto.		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
9. DATE OF BIRTH JULY 20, 1900		10. AGE (In years lost birthday) 71		E. STREET AND NUMBER 6414 Park Heights Avenue, apt. G2			
11. BIRTHPLACE (State or foreign country) LATVIA		12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME MARKUS KAHAN			
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MFG. PAINT CHEMIST		14B. KIND OF BUSINESS OR INDUSTRY MERCHANT		15. MOTHER'S MAIDEN NAME FANNIE LONDON			
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) YES W.W. I NAVY		17. SOCIAL SECURITY NO. 135-05-2435		18. INFORMANT ADDRESS MRS. RENEE KAHAN, 6414 PK. HGHTS. AVE., APT. G2			
19. 4/12/72 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease		CAUSE OF DEATH Arteriosclerotic cardiovascular disease					
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:					
		(B) DUE TO, OR AS A CONSEQUENCE OF:					
		(C) DUE TO, OR AS A CONSEQUENCE OF:					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED					21. AUTOPSY? (Yes or No) yes
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?			
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?			
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Peter Lipkovic M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) Peter Lipkovic, M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED 4/14/72 ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>							
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 4-16-72		24C. NAME of CEMETERY or CREMATORY BETH TFILOH		24D. LOCATION (City, town, or county) (State) BALTIMORE, MARYLAND	
25A. DATE REC'D BY HEALTH DEPT. APR 19 1972		25B. NAME OF REGISTRAR Robert J. ...		25C. FUNERAL DIRECTOR ADDRESS SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD			

JULY 20, 1900
 YES
 W. F. I. NAVY
 125-12-2222 MR. NINE KANAN, 6014 F. HIGGS AVE., WY., DC.
 MR. PAINT GEMIST
 USA
 HARRIS KANAN
 PACIFIC LADDER

BUREAU
 4-16-11
 WITH YINING
 BATTLESHIP, HAWAII

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. <u>72 03762</u>
BIRTH NO. <u>U-310</u>		72 03762		
1. NAME OF DECEASED (Type or Print) <u>IDA UDOFF</u>		2. DATE AND HOUR OF DEATH <u>4-16-72</u> <u>12:10</u> P. M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institutions residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>2716</u>		
FULL NAME OF HOSPITAL OR INSTITUTION <u>Sinai Hospital of Baltimore</u> <u>42</u>		C. CITY OR TOWN <u>Balt.</u> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		
5. SEX <u>FEMALE</u>		6. RACE <u>XX WHITE</u>		
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>10-15-98</u>		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>AT HOME</u>		
13. FATHER'S NAME <u>ZUNDEL GERSTEIN</u>		14. MOTHER'S MAIDEN NAME <u>CHANE CANTORROVITH</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>214-24-1028</u>		
17. INFORMANT <u>MRS. ROSE HANENBAUM, 3005 ROMARIC CT., APT. H.</u>		ADDRESS		
18. <u>18301</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>Cardio respiratory failure</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Ovarian carcinoma</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (1) (this hospital) attended the deceased from <u>4-5-72</u> to <u>4-16-72</u> that (1) (we) last saw the deceased alive on <u>4-16-72</u> and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <u>Rogelio Libon-on</u> M.D.		23B. DATE SIGNED <u>4-16-72</u>		23C. PHYSICIAN'S NAME (Type) <u>ROGELIO LIBON-ON</u> M.D.
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>4-17-72</u>		24C. NAME of CEMETERY or CREMATORY <u>RODFE ZEDEK</u>
25A. DATE REC'D BY HEALTH DEPT. <u>APR 19 1972</u>		25B. NAME OF REGISTRAR <u>Sol Levinson</u>		25C. FUNERAL DIRECTOR <u>SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD</u>
25D. LOCATION <u>BALTIMORE, MARYLAND</u>		25E. ADDRESS <u>6010 REISTERSTOWN ROAD</u>		

WISDOM XXXX

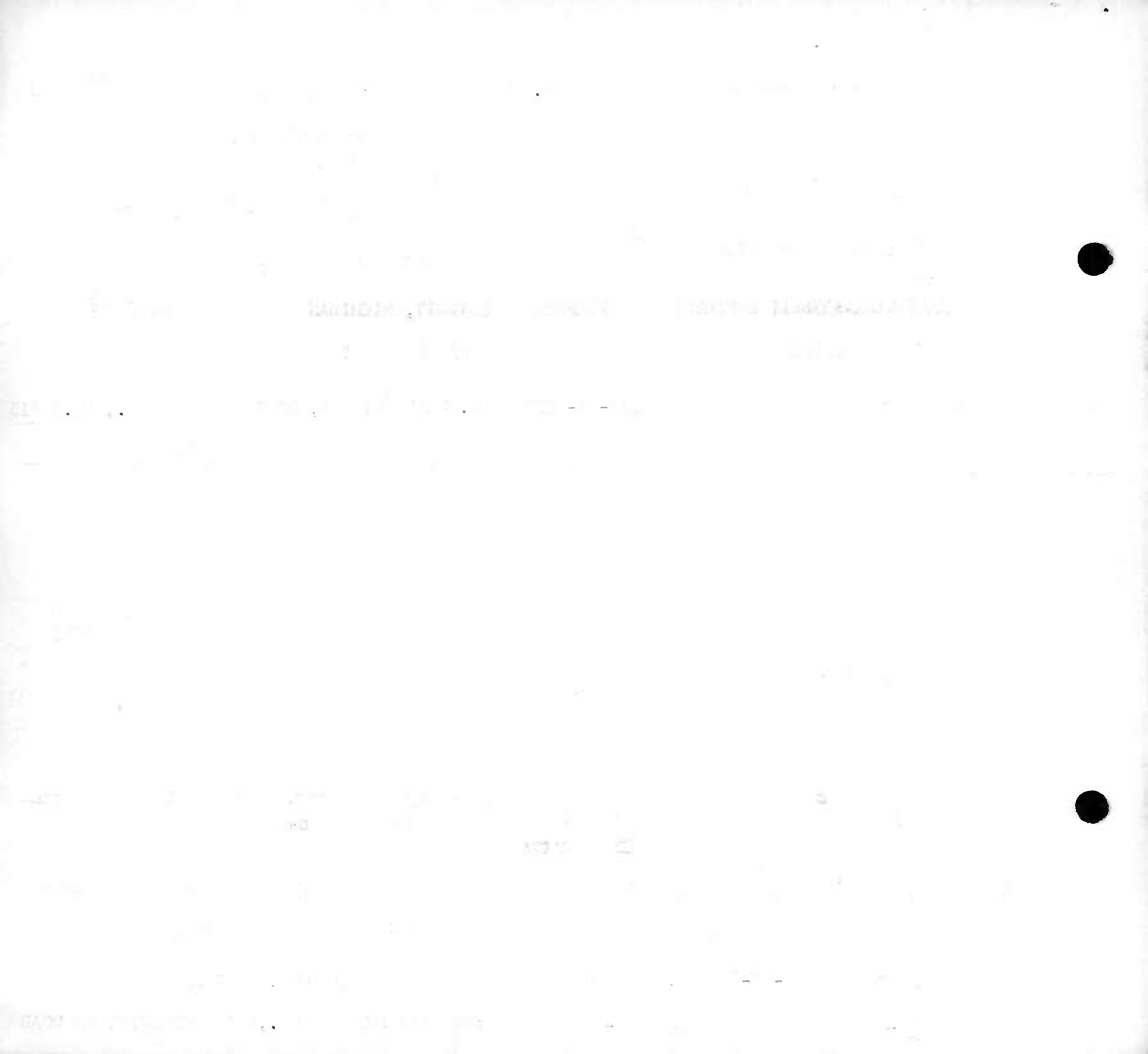
as 'WISDOM' is

... ..

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

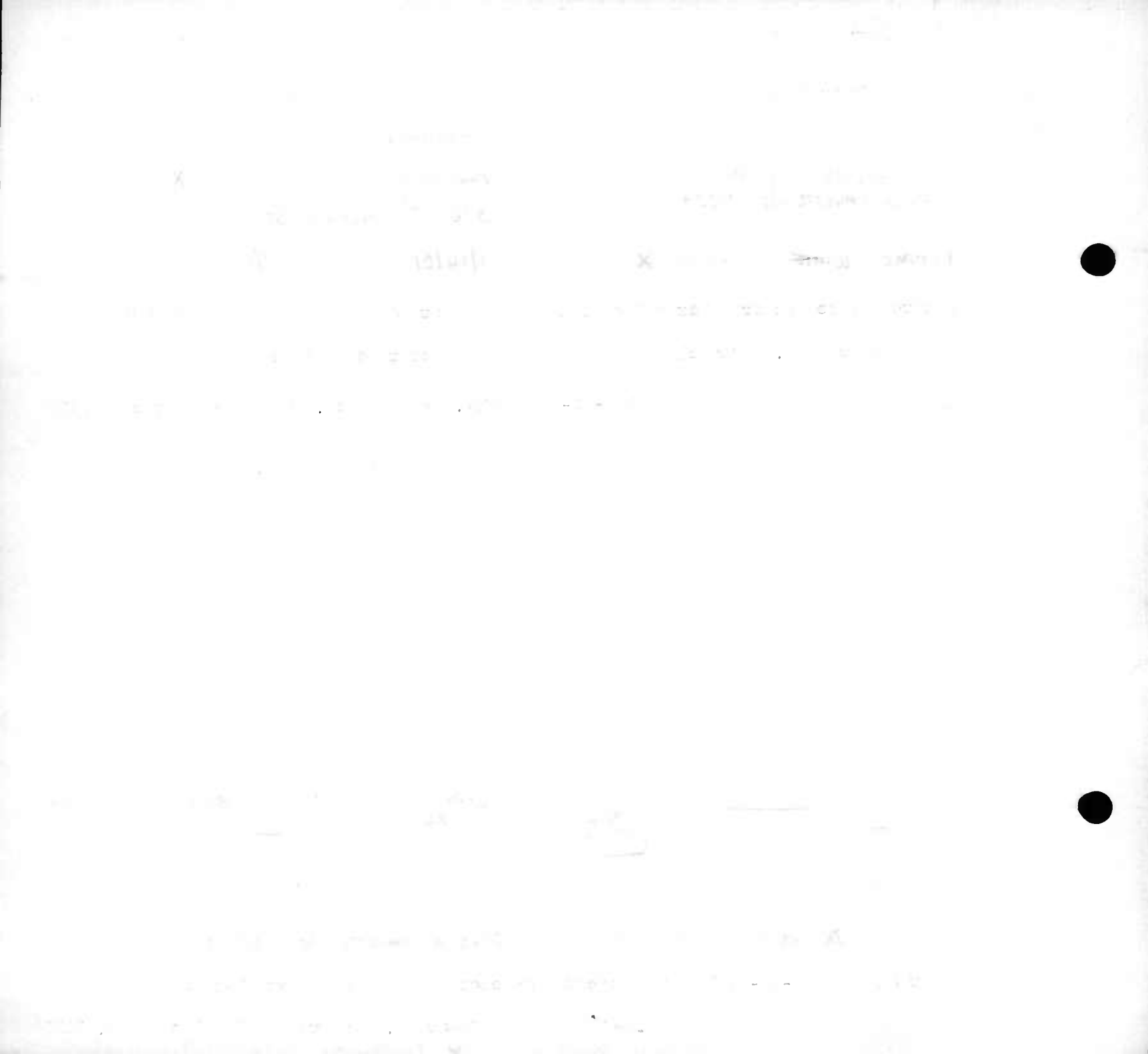
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>72 03763</u>
BIRTH NO. <u>S-534</u>		72 03763		CERTIFICATE OF DEATH
1. NAME OF DECEASED (Type or Print) <u>SHINDEL, ROBERT S. SHINDEL</u>		2. DATE AND HOUR OF DEATH <u>4-16-72</u> <u>10:35</u> <u>AM.</u>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>42 SINAI HOSPITAL</u>		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <u>MD.</u> B. COUNTY <u>BALTIMORE</u> C. CITY OR TOWN <u>BALTIMORE</u> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>3103 BANCROFT RD. #15</u>		
5. SEX <u>MALE</u>	6. RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-9-17</u>	9. AGE (In years last birthday) <u>54</u> If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SELF EMPLOYED</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>PLUMBER</u>		11. BIRTHPLACE (State or foreign country) <u>DETROIT, MICHIGAN</u>
13. FATHER'S NAME <u>HYMAN SHINDEL</u>		14. MOTHER'S MAIDEN NAME <u>SARAH ?</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>212-01-6272</u>		17. INFORMANT ADDRESS <u>MRS. MARY SHINDEL, 3103 BANCROFT RD., APT. A #15</u>
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>VOLVULUS OF SIGMOID COLON- RECURRENT</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 MONTH</u>		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>PARKINSONISM</u>		SEVERAL YEARS		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				
19A. DATE OF OPERATION <u>3-23-72</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>SIGMOID VOLVULUS</u>		20A. AUTOPSY? (Yes or No) <u>NO</u>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <u>NO</u>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (this hospital) attended the deceased from <u>3-15</u> 19 <u>72</u> to <u>4-16</u> 19 <u>72</u> that (we) last saw the deceased alive on <u>4-16</u> 19 <u>72</u> and that in (our) opinion death occurred on the date and hour and from the causes stated above. (I) (did) view the body after death.				
23A. SIGNATURE <u>Ronald P. Byank, M.D. 9006</u>				23B. DATE SIGNED <u>4-16-72</u>
23C. PHYSICIAN'S NAME (Type) <u>R. P. BYANK, M.D.</u>		23D. ADDRESS <u>SINAI HOSPITAL</u>		
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>	24B. DATE <u>4-17-72</u>	24C. NAME OF CEMETERY or CREMATORY <u>AITZ CHAIM</u>		24D. LOCATION (City, town, or county) (State) <u>BALTIMORE, MARYLAND</u>
25A. DATE REC'D BY HEALTH DEPT. <u>APR 19 1972</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor, Jr.</u>		25C. FUNERAL DIRECTOR ADDRESS <u>SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD</u>



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>72 03764</u>	
<div style="display: flex; justify-content: space-between;"> BIRTH NO. <u>K-652</u> 72 03764 CERTIFICATE OF DEATH </div>					
1. NAME OF DECEASED (Type or Print) <u>KEARNS MARIE G.</u>			2. DATE AND HOUR OF DEATH <u>4/16/72</u> <u>3:05</u> <u>12</u> <u>M.</u>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <u>BON SECOURS HOSPITAL</u> <u>2025 W. FAYETTE ST. 21223</u>			A. STATE <u>MARYLAND</u>		1903 D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			B. COUNTY		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			C. CITY OR TOWN <u>BALTIMORE</u>		E. STREET AND NUMBER <u>326 S. GILMORE ST.</u>
5. SEX <u>FEMALE</u>	6. RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1/14/01</u>	9. AGE (in years last birthday) <u>71</u>	If Under 1 Yr. Months: Days: Hours: Min. If Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired House Mother</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Mercy Hospital</u>	11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>James W. Gosnell</u>			14. MOTHER'S MAIDEN NAME <u>Gertrude Boyle</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>212-09-8681</u>	17. INFORMANT <u>Mrs. John Bailey. 1200 James Street 21223</u>		
MEDICAL CERTIFICATION					
18. CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Cardiac failure</u> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:					
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Heart Diabetes</u> (B) DUE TO, OR AS A CONSEQUENCE OF:					
(C)					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from <u>6/29</u> 19 <u>71</u> to <u>3/16</u> 19 <u>72</u> that (I) (we) last saw the deceased alive on <u>3/16</u> 19 <u>72</u> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Stephen H. Bennett</u>				23B. DATE SIGNED <u>4/16/72</u>	
23C. PHYSICIAN'S NAME (Type) <u>DR. STEPHEN H. BENNETT</u>				23D. ADDRESS <u>2025 W. FAYETTE ST. 21223</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>4-19-1972</u>		24C. NAME OF CEMETERY OR CREMATORY <u>New Cathedral Cemetery</u>	
24D. LOCATION <u>Baltimore, Maryland</u>					
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR <u>Howard H. Hubbard, 4107 Wilkens Ave. 21229</u>	
APR 19 1972					



W. 436

S-363

72 03765

BALTIMORE CITY HEALTH DEPARTMENT

72 03765

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Edmund L. Stuart

(Wlodarczyk)

2. DATE
OF
DEATHKnown ☒
Estimated ☐Month
4Day
17Year
72Hour
6:41 P. M.4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD
FULL NAME OF HOSPITAL
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

35 Church Home & Hospital

3. DATE
PRONOUNCED DEADMonth
4Day
17Year
72Hour
6:41 P. M.

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Maryland

B. COUNTY

#21224

103

6. SEX

Male

7. RACE

White

8. MARRIED ☐ NEVER MARRIED ☒
WIDOWED ☐ DIVORCED ☐

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒NO ☐

9. DATE OF BIRTH

Nov. 1, 1916

10. AGE (In years
last birthday)

55

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

11. BIRTHPLACE (State or foreign country)

Baltimore, Maryland

12. CITIZEN OF
WHAT COUNTRY?

U. S. A.

13. FATHER'S NAME

Stanislaus X. Wlodarczyk

14. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Inspector

14B. KIND OF BUSINESS OR INDUSTRY

Western Elect. Co.

15. MOTHER'S MAIDEN NAME

Eva G. Kozlowski

16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

17. SOCIAL
SECURITY NO.

220-05-8461

18. INFORMANT

ADDRESS

Eva G. Wlodarczyk - 616 S. Lakewood Ave. 21224

19.

571.81

CAUSE OF DEATH

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) IMMEDIATE CAUSE Fatty alteration of liver
DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.(B) _____
DUE TO, OR AS A CONSEQUENCE OF:

(C) _____

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART 1 (A).

20A. DATE OF OPERATION

2

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

Yes

22A. EXTERNAL CAUSE WAS
UNDERLYING ☐ OR CONTRIB-
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg., etc.)22C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?22D. TIME (Month) (Day) (Year) (Hour)
OF INJURY
(APPROX.)

22E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Werner V. Spitz, M.D.

M.D.

Deputy CHIEF MEDICAL EXAMINER ☒ASSISTANT MEDICAL EXAMINER ☐ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

4-18-72

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

4/21/72

24C. NAME OF CEMETERY or CREMATORY

St. Stanislaus Cemetery

24D. LOCATION (City, town, or county)

Baltimore, Maryland

(State)

25A. DATE REC'D BY HEALTH DEPT.

APR 19 1972

25B. NAME OF REGISTRAR

Robert E. Farber, M.D.

25C. FUNERAL DIRECTOR

George A. Weber - 705 S. Ann St. #21231

ADDRESS

()

75 0000

75 0000

75 0000

75 0000

75 0000

75 0000

75 0000

75 0000

75 0000

75 0000

75 0000

WALLEY BOIR

WALLEY BOIR

75 0000

75 0000

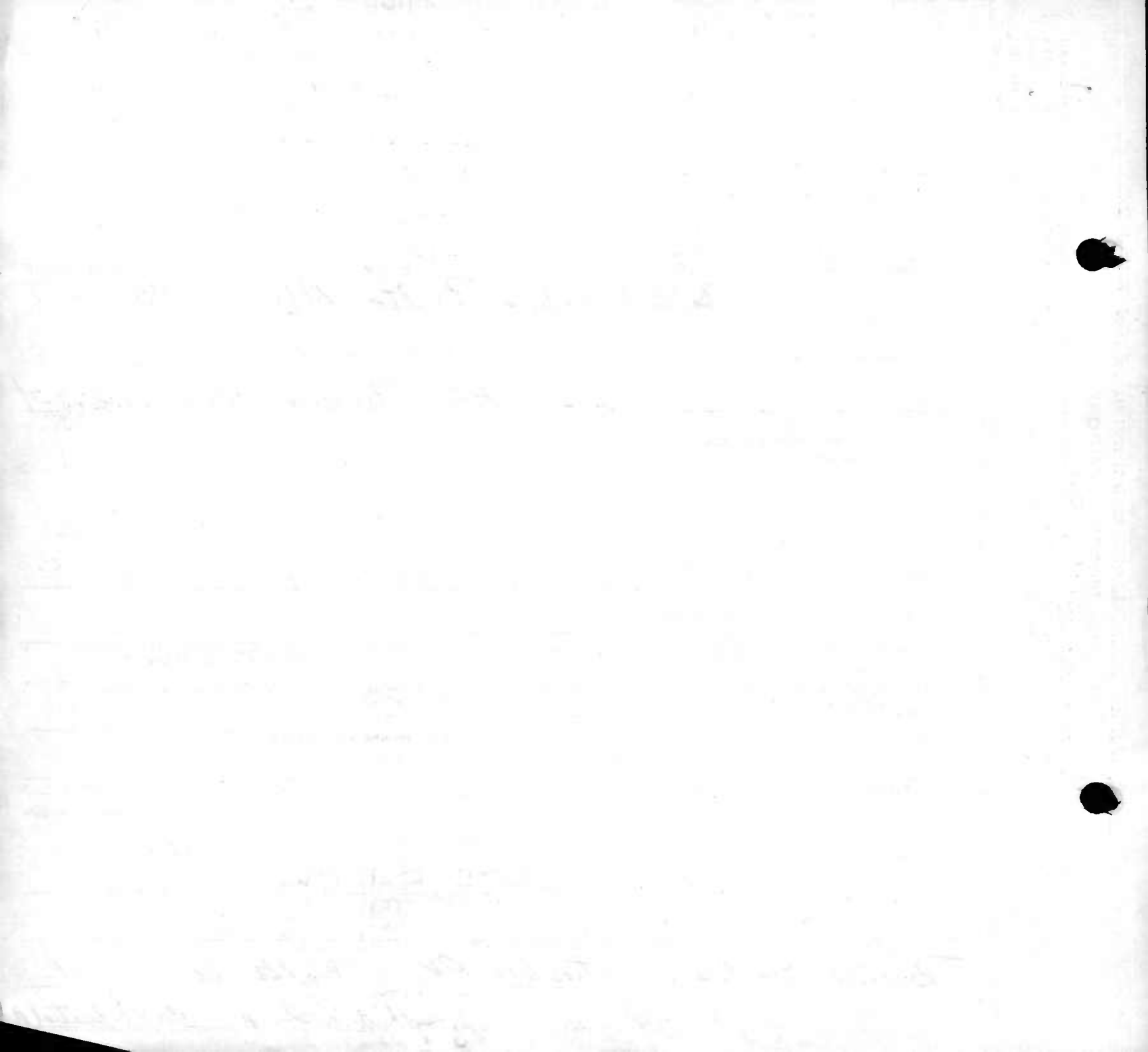
75 0000

THE BODY OF WAYMAN BROWN HAS BEEN RELEASED AS NON MED BY DR KORNBLUTH OF THE

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-650 72 03766				BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 03766	
BIRTH NO.				1. NAME OF DECEASED			
WAYMAN BROWN				2. DATE AND HOUR OF DEATH			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				04-16-72 6:30 A. M.			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
THE JOHNS HOPKINS HOSPITAL				A. STATE B. COUNTY			
BALTIMORE, MD 21205				C. CITY OR TOWN D. INSIDE CITY LIMITS?			
				BALTIMORE YES X NO			
				E. STREET AND NUMBER			
				813 N. CAROLINE STREET			
5. SEX		6. RACE		7. MARRIED X NEVER MARRIED		8. DATE OF BIRTH	
MALE		NEGRO		WIDOWED DIVORCED		9. AGE (in years last birthday) 59	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
		Balto Public Health		Balto, MD		U.S.	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
WAYMON BROWN				BETTY DAVENPORT			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
No				213-12-8604		AMY BROWN 813 N. Caroline St.	
18. 441.2 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				CAUSE OF DEATH			
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
ANTECEDENT CAUSES				CARDIAC ARREST 5 MIN			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) UNCONTROLLABLE BLEEDING 4 HRS			
				(C) RUPTURED ABD AORTIC ANEURYSM 6 HRS			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
4/16/72		RUPTURED ABD AORT. ANEURYSM		NO			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR?		(If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
		While At Work Not While At Work					
22. I certify that (I) (this hospital) attended the deceased from 4/15/72 19 to 4/16/72 19 that (I) (we) last saw the deceased alive on 4/16/72 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE				23B. DATE SIGNED			
ROY A. MGALE MD				4/16/72			
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
ROY A. MGALE				JOHNS HOPKINS HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial		4/20/72		Arbutus Mem. Pk.		Balto Co. Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
APR 10 1972		Robert E. Taylor		Joseph J. Locke Jr.		1307 N. E.	



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

72 03767

REG. NO.

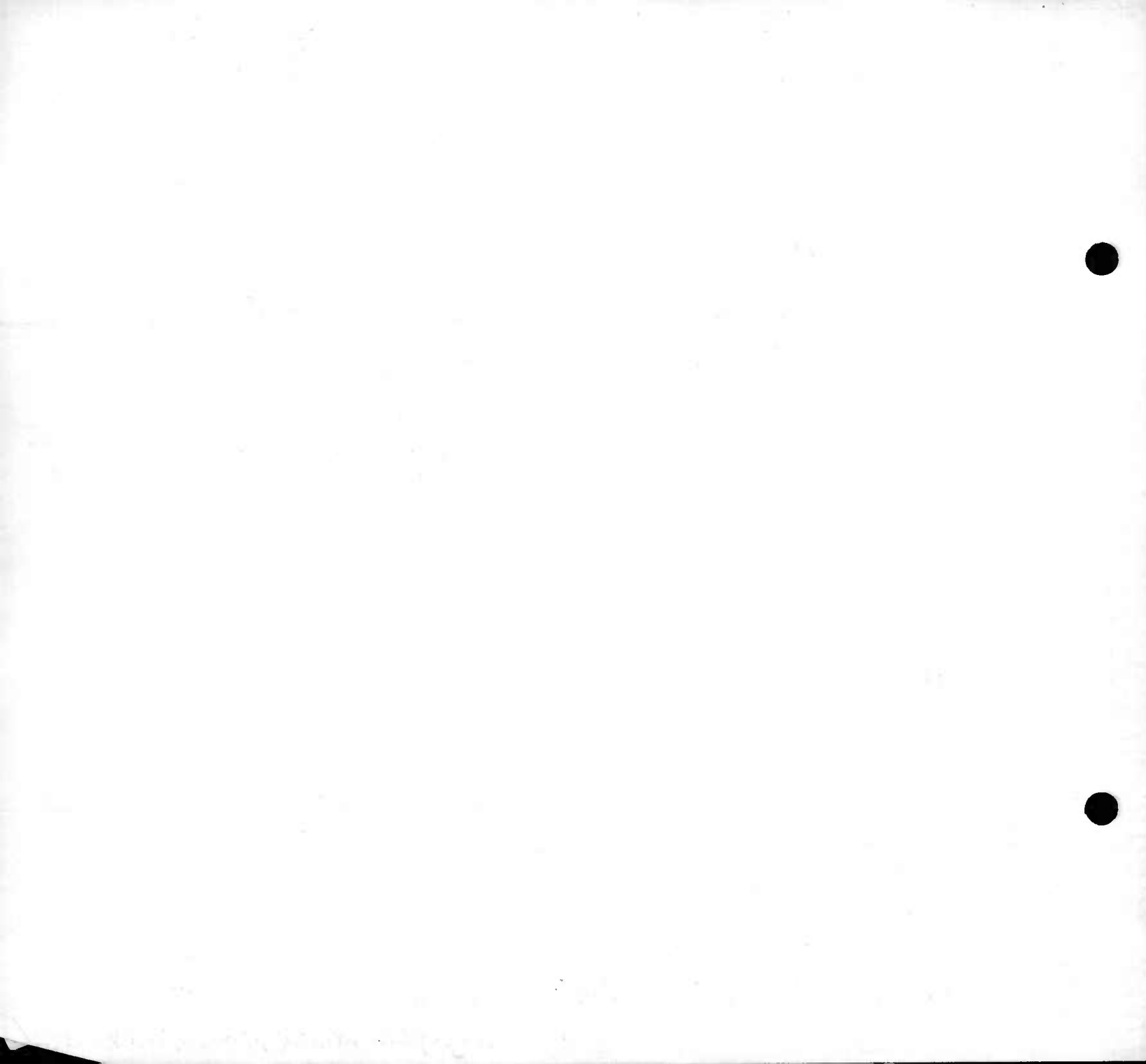
BIRTH NO.

1. NAME OF DECEASED (Type or Print) WILLIAM HENRY		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 46 LUTHERAN HOSPITAL		3. DATE PRONOUNCED DEAD Month Day Year April 15, 1972 Hour 1:50 P.M.	
6. SEX Male		7. RACE Negro	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore	
D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
9. DATE OF BIRTH Aug. 3, 1925		10. AGE (In years last birthday) 46	
11. BIRTHPLACE (State or foreign country) Wilmington N.C.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME William Henry		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) La Bonera	
15. MOTHER'S MAIDEN NAME Flossie Henry		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) Yes WW 2	
17. SOCIAL SECURITY NO. 216-8-0159		18. INFORMANT Patricia Bowen ADDRESS 1109 Harlem Ave	
19. E965X		CAUSE OF DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)		Peritonitis and Bronchopneumonia	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Gunshot wound of Abdomen (B) DUE TO, OR AS A CONSEQUENCE OF: (C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) yes			
22A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Unknown	
22C. WHERE DID INJURY OCCUR? 1106 Edmondson Avenue			
22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.) 4-6-72 5:34 P.M.		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	
22F. HOW DID INJURY OCCUR? Shot			
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Ronald N. Kornblum, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) Ronald N. Kornblum, M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 4/16/72			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4/22/72	
24C. NAME OF CEMETERY or CREMATORY Mt. Auburn Cem		24D. LOCATION (City, town, or county) (State) Balto Md	
25A. DATE REC'D BY HEALTH DEPT. APR 19 1972		25B. NAME OF REGISTRAR Patricia Bowen	
25C. FUNERAL DIRECTOR Williams Funeral Home		25D. ADDRESS 399 N. Schroeder	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. <u>72 03768</u>	
BIRTH NO. <u>M-320</u> <u>72 03768</u>					
1. NAME OF DECEASED (Type or Print) <u>MATTHEWS, Edith E.</u>		2. DATE AND HOUR OF DEATH <u>4-16-72</u> <u>3:20 p.m.</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MD.</u> B. COUNTY <u>1547</u>			
FULL NAME OF HOSPITAL OR INSTITUTION <u>Montebello State Hosp.</u>		C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
91		E. STREET AND NUMBER <u>5318 Poplar Grove St.</u>			
5. SEX <u>Female</u>	6. RACE <u>Colored</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-4-27</u>	9. AGE (In years last birthday) <u>44</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>COOK</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland, Balto.</u>	
13. FATHER'S NAME <u>Roland Matthews</u>		14. MOTHER'S MAIDEN NAME <u>Cora Thomas</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>320-20-3819</u>		17. INFORMANT <u>James Matthews</u> ADDRESS	
18. <u>174X I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH <u>Metastatic Carcinoma to lungs</u> (A) IMMEDIATE CAUSE <u>Pelvic cavity, returning</u> DUE TO, OR AS A CONSEQUENCE OF: <u>Sarcoma</u> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) <u>Breast Adenocarcinoma</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>5 yrs.</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		<u>Urinary tract infection</u>		<u>6 m+2</u>	
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>NO</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (X) (this hospital) attended the deceased from <u>2-22</u> 19 <u>72</u> to <u>4-16</u> 19 <u>72</u> that (X) (we) last saw the deceased alive on <u>4-16</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>[Signature]</u>		23B. DATE SIGNED <u>4-16-72</u>		23C. PHYSICIAN'S NAME (Type) <u>R. J. DUREZA</u> M.D. DEGREE	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>4/20/72</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Arbutus Memorial Park</u>	
24D. LOCATION (City, town, or county) <u>Baltimore</u>		24E. STATE <u>MD</u>		25A. DATE REC'D BY HEALTH DEPT. <u>APR 19 1972</u>	
25B. NAME OF REGISTRAR <u>Robert E. Seiber</u>		25C. FUNERAL DIRECTOR <u>Williams Funeral Home</u>		25D. ADDRESS <u>3917 Lakewood Rd.</u>	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Underdetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 03769	
BIRTH NO. 72 03769				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <u>CLARK, CATHERINE</u>		2. DATE AND HOUR OF DEATH <u>4-16-72</u> <u>11:45 P</u> M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>41 MONTEBELLO STATE HOSPITAL</u>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MD.</u> B. COUNTY <u>1702</u>			
5. SEX <u>F</u>		6. RACE <u>N</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>		10B. KIND OF BUSINESS OR INDUSTRY		8. DATE OF BIRTH <u>11-14-1909</u>	
13. FATHER'S NAME <u>Arthur Banger</u>		14. MOTHER'S MAIDEN NAME <u>Mary</u>		9. AGE (In years last birthday) <u>62</u> If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>PATIENT'S CHART</u>	
18. <u>161.9 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <u>Carcinomatosis</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>4 mos. +</u>			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Ca of the Larynx</u>		(B) <u>Ca of the Larynx</u> DUE TO, OR AS A CONSEQUENCE OF: <u>6 mos. +</u>			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <u>II</u>		19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Pathological Fracture @ Hip One mo. +</u>	
20A. AUTOPSY? (Yes or No) <u>Yes</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>No</u>			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indify medical examined) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <u>W</u> (this hospital) attended the deceased from <u>4-4</u> 19 <u>72</u> to <u>4-16</u> 19 <u>72</u> that <u>W</u> (we) last saw the deceased alive on <u>4-16</u> 19 <u>72</u> and that <u>W</u> (our) opinion death occurred on the date and hour and from the causes stated above. <u>W</u> (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>R. J. Dureza</u>		23B. DATE SIGNED <u>4-16-72</u>		23C. PHYSICIAN'S NAME (Type) <u>R. J. Dureza M.D.</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>4/22/72</u>		24C. NAME OF CEMETERY or CREMATORY <u>MT Auburn Cemetery</u>	
24D. LOCATION <u>Baltimore, MD</u>		25A. DATE REC'D BY HEALTH DEPT. <u>APR 19 1972</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor, R.D.</u>	
25C. FUNERAL DIRECTOR <u>Adolphus Halstead</u>		25D. ADDRESS <u>1206 W. North Ave</u>			



J-520

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BIRTH NO.

72 03770

REG. NO.

72 03770

1. NAME OF DECEASED (Type or Print) ULYSSES JONES		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 1418 Druid Hill Avenue		3. DATE PRONOUNCED DEAD Month Day Year Hour April 4, 1972 8:00 P.	
6. SEX Male		7. RACE Negro	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore	
9. DATE OF BIRTH		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
10. AGE (In years lost birthday) 63		E. STREET AND NUMBER 1418 Druid Hill Avenue	
11. BIRTHPLACE (State or foreign country) South Carolina		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Edmund Jones		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer	
15. MOTHER'S MAIDEN NAME Mattie		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	
17. SOCIAL SECURITY NO.		18. INFORMANT Miss Mary Jones	
19. 4/2/72		ADDRESS 1728 Linden Ave	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		CAUSE OF DEATH Arteriosclerotic cardiovascular disease (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:	
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) no		22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	
22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?		23.	
I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL EXAMINER'S NAME (Type) Ronald N. Kornblum, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
DATE SIGNED 4/5/72			
24A. BURIAL CREMATION, REMOVAL (Specify) burial		24B. DATE 4/19/72	
24C. NAME OF CEMETERY or CREMATORY MT Calvary Cemetery		24D. LOCATION (City, town, or county) (State) A A County Md	
25A. DATE REC'D BY HEALTH DEPT. APR 19 1972		25B. NAME OF REGISTRAR Robert E. Tabor, R.D.	
25C. FUNERAL DIRECTOR Adolphus Halstead		ADDRESS 1206 W North A	

0077 - 51

ATLAS OF THE STATE OF NEW YORK

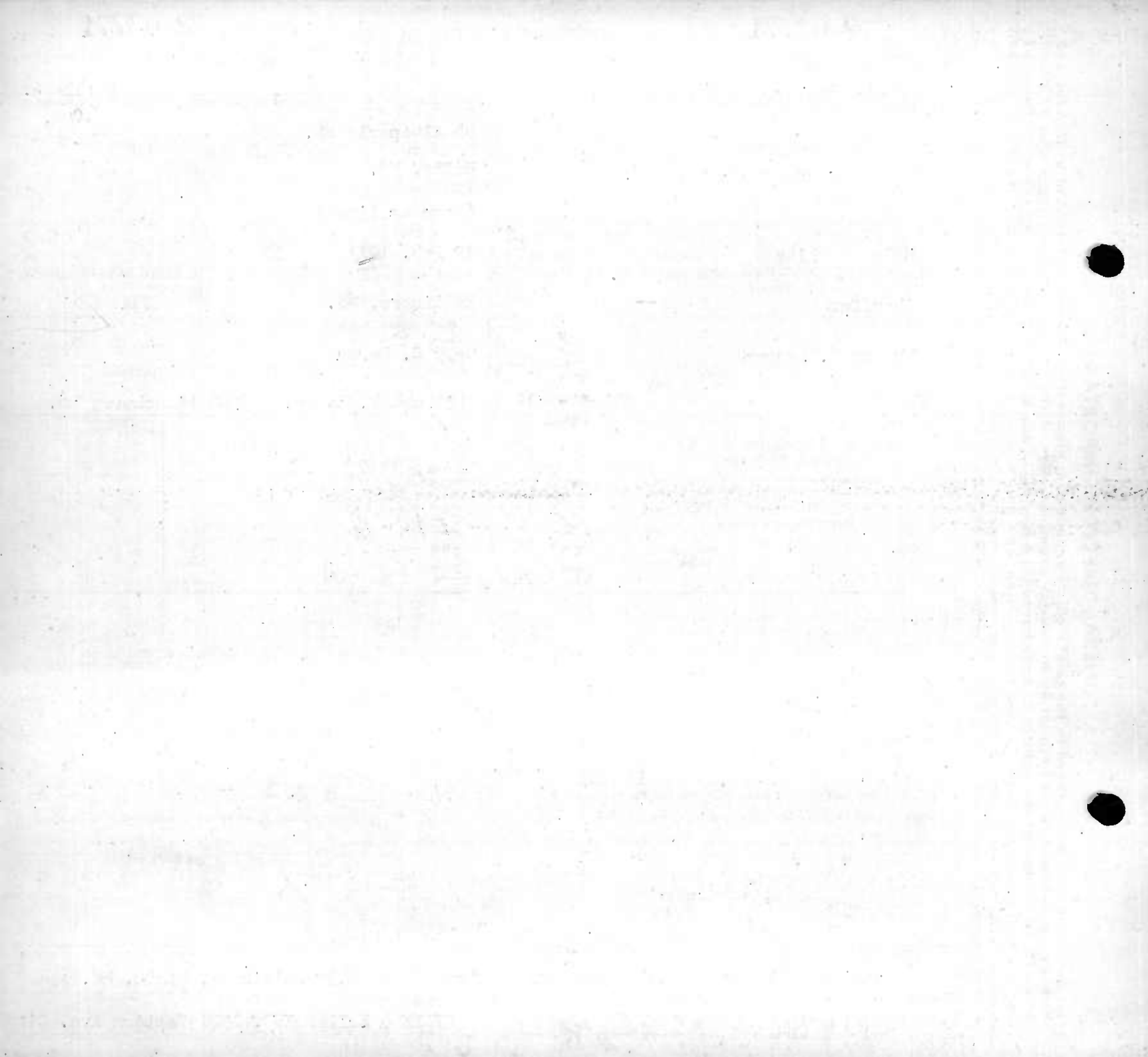
1890

CHAMBERS

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>72 03771</u>	
BIRTH NO. <u>72 03771</u>			CERTIFICATE OF DEATH		
1. NAME OF DECEASED (Type or Print) <u>Baumer, Thomas</u>			2. DATE AND HOUR OF DEATH <u>4/19/72</u> <u>12:45 A.M.</u>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>37</u> <u>Mercy Hospital, Inc.</u>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MD</u> B. COUNTY <u>362</u> C. CITY OR TOWN <u>Balto, Md.</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>(Same as line A)</u>		
5. SEX <u>Male</u>	6. RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>19 Feb. 1913</u>	9. AGE (In years lost birthday) <u>59</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Chauffer</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>--</u>	11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>Thomas C. Baumer</u>			14. MOTHER'S MAIDEN NAME <u>Mary J. Beran</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>217-01-5619</u>	17. INFORMANT ADDRESS <u>Philbert F. Baumer 3527 Wildcherry Rd.</u>		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) <u>Aspiration</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Croup & lung</u> <u>CO PD, TBC - old</u>			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>4/12/72</u> 19 <u>72</u> to <u>4/19</u> 19 <u>72</u> , that (I) (we) last saw the deceased alive on <u>4/18</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) <u>(did)</u> (did not) view the body after death.					
23A. SIGNATURE <u>M. E. Kelster</u>			23B. DATE SIGNED		23C. PHYSICIAN'S NAME (Type) <u>M. E. Kelster</u>
23D. ADDRESS <u>Mercy Hosp.</u>			23E. DEGREE		
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>	24B. DATE <u>22 Apr</u>	24C. NAME OF CEMETERY OR CREMATORY <u>Holy Redeemer Cemetry</u>	24D. LOCATION (City, town, or county) (State) <u>4430 Belair Rd, Balto, Md.</u>		
25A. DATE REC'D BY HEALTH DEPT. <u>APR 19 1972</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor</u>	25C. FUNERAL DIRECTOR ADDRESS <u>LILLY & ZEILER INC, 1901 Eastern Ave. City</u>		

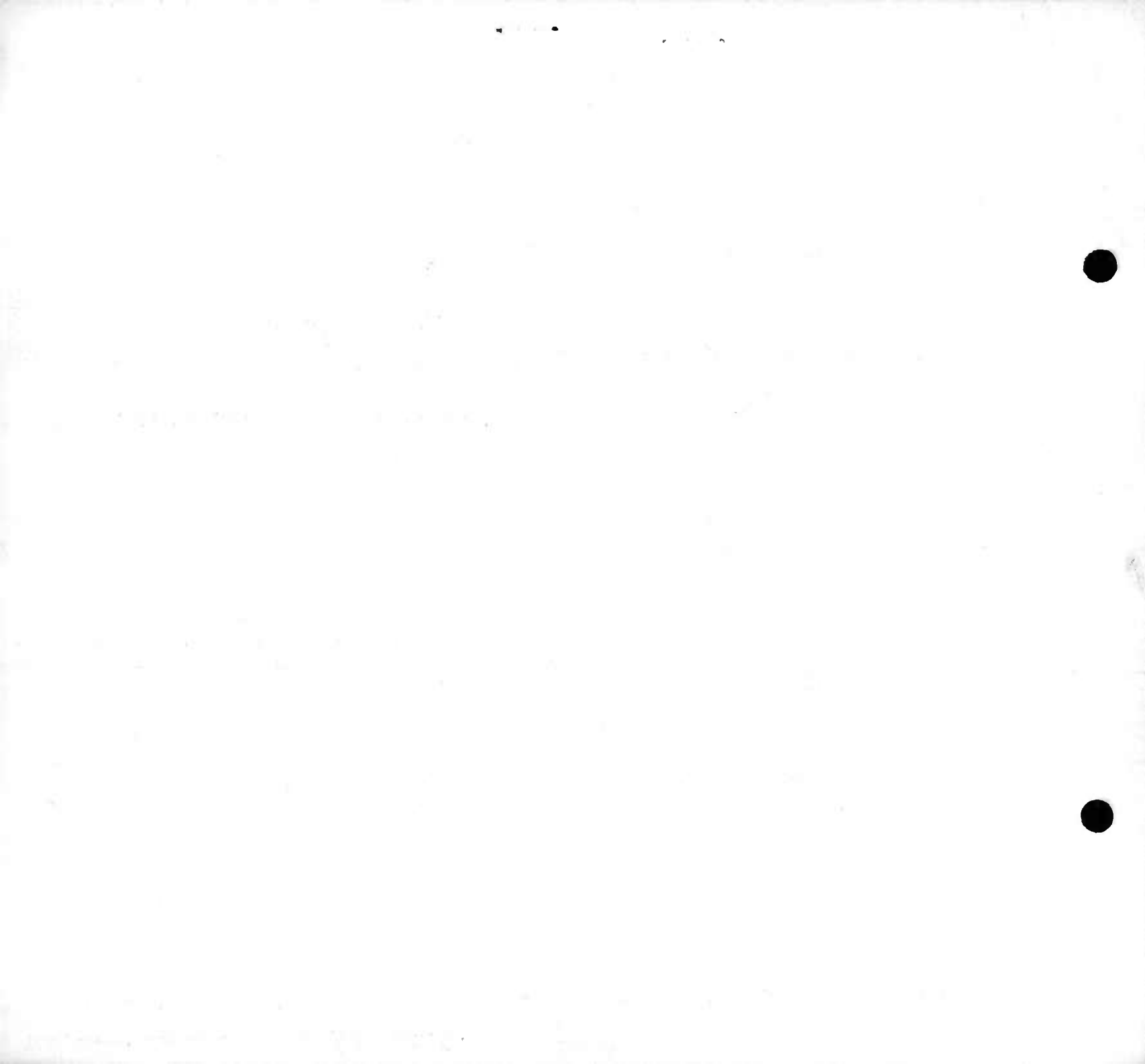


Released on approval
Dr. Spitz - H.E.O. #408

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

FUNERAL DIRECTOR: IMPORTANT

BALTIMORE CITY HEALTH DEPARTMENT																			
72 03772					CERTIFICATE OF DEATH		REG. NO. 72 03772												
BIRTH NO.					1. NAME OF DECEASED (Type or Print)					2. DATE AND HOUR OF DEATH									
					Hill, Joseph (St Clair)					11 April 1972 1040 P.M.									
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD					4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)					A. STATE B. COUNTY									
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)					Md St Mary's					C. CITY OR TOWN D. INSIDE CITY LIMITS?									
38 University Hosp					Mechanicsville					YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
5. SEX		6. RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday)		If Under 1 Yr. Months		If Under 24 Hrs. Days Hours Min.							
male		white				2/23/61		11											
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)					10B. KIND OF BUSINESS OR INDUSTRY					11. BIRTHPLACE (State or foreign country)					12. CITIZEN OF WHAT COUNTRY?				
none										Maryland					USA				
13. FATHER'S NAME										14. MOTHER'S MAIDEN NAME									
James St Clair Hill										Mary Rose Norris									
15. Was Deceased Ever In U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)					16. SOCIAL SECURITY NO.					17. INFORMANT ADDRESS									
no					none					J. St Clair Hill Mechanicsville, Maryland									
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH										CAUSE OF DEATH					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH										① Cerebral contusion, severe									
(This does not mean the mode of dying, e.g., from infection, trauma, etc., but the disease, injury or complication which caused death.)										(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:									
ANTECEDENT CAUSES										(B) DUE TO, OR AS A CONSEQUENCE OF:									
DISEASES OR CONDITIONS IMMEDIATELY giving rise to the above cause (A) stating the UNDERLYING CONDITION last.										(C) DUE TO, OR AS A CONSEQUENCE OF:									
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).										Bilateral tension pneumothorax, flail chest, multiple rib fractures, pulmonary contusion									
19A. DATE OF OPERATION					19B. CONDITION FOR WHICH OPERATION WAS PERFORMED					20A. AUTOPSY? (Yes or No)					20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
none										yes									
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)					21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)					21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)									
					Street (5)					St Mary's, Md 6800									
21D. TIME OF INJURY (APPROX.)					21E. INJURY OCCURRED					21F. HOW DID INJURY OCCUR?									
4 10 72 7PM					While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>					Hit by car									
22. I certify that (I) (this hospital) attended the deceased from										10 April 1972 to 11 April 1972									
that (I) (we) lost saw the deceased alive on										19 and that in (my) (our) opinion death occurred on the date									
and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.																			
23A. SIGNATURE					23B. DATE SIGNED														
Kagosa m					4 April 72														
23C. PHYSICIAN'S NAME (Type)					23D. ADDRESS														
					University Hospital														
24A. BURIAL CREMATION, REMOVAL (Specify)					24B. DATE					24C. NAME of CEMETERY or CREMATORY					24D. LOCATION (City, town, or county) (State)				
Burial					April 14, 1972					St Josephs Cemetery					Morganza, St Mary's, Maryland				
25A. DATE REC'D BY HEALTH DEPT.					25B. NAME OF REGISTRAR					25C. FUNERAL DIRECTOR ADDRESS									
APR 19 1972					P. J. E. F. B. & Co.					W. Clarke Mattingley Leonardtown, Maryland									



BALTIMORE CITY HEALTH DEPARTMENT				72 03773			
MEDICAL EXAMINER'S CERTIFICATE OF DEATH				72 03773			
BIRTH NO. 71-19720				REG. NO.			
1. NAME OF DECEASED (Type or Print) STANLEY E. FITZGERALD				2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.			
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 1202 N. Bond Street				3. DATE PRONOUNCED DEAD Month Day Year Hour April 15, 1972 11:50 A.M.			
5. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY 808							
6. SEX Male		7. RACE Negro		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore	
9. DATE OF BIRTH 11-17-71		10. AGE (In years lost birthday) 5		11. BIRTHPLACE (State or foreign country) Maryland		E. STREET AND NUMBER 1202 N. Bond Street	
12. CITIZEN OF U.S.		13. FATHER'S NAME Stanley E. Fitzgerald		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		15. MOTHER'S MAIDEN NAME Sandra Ann Wallace	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO.		18. INFORMANT Sandra Ann Wallace		ADDRESS 1202 N. Bond St.	
19. 795X1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				CAUSE OF DEATH Sudden death in infancy (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:			
20A. DATE OF OPERATION				20B. CONDITION FOR WHICH OPERATION WAS PERFORMED			
21. AUTOPSY? (Yes or No) yes							
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIB-UTING <input type="checkbox"/> CAUSE OF DEATH.				22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?							
22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)				22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			
22F. HOW DID INJURY OCCUR?							
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Ronald N. Kornblum M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) Ronald N. Kornblum, M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED 4/16/72 ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>							
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial		4-19-72		Mt. Calvary Cem.		A. A. County, Md.	
25A. DATE REC'D BY HEALTH DEPT. APR 19 1972		25B. NAME OF REGISTRAR Robert E. Fisher, M.D.		25C. FUNERAL DIRECTOR Milton E. Ellickson		ADDRESS 1297 Canton St.	

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

72 03774

BIRTH NO.

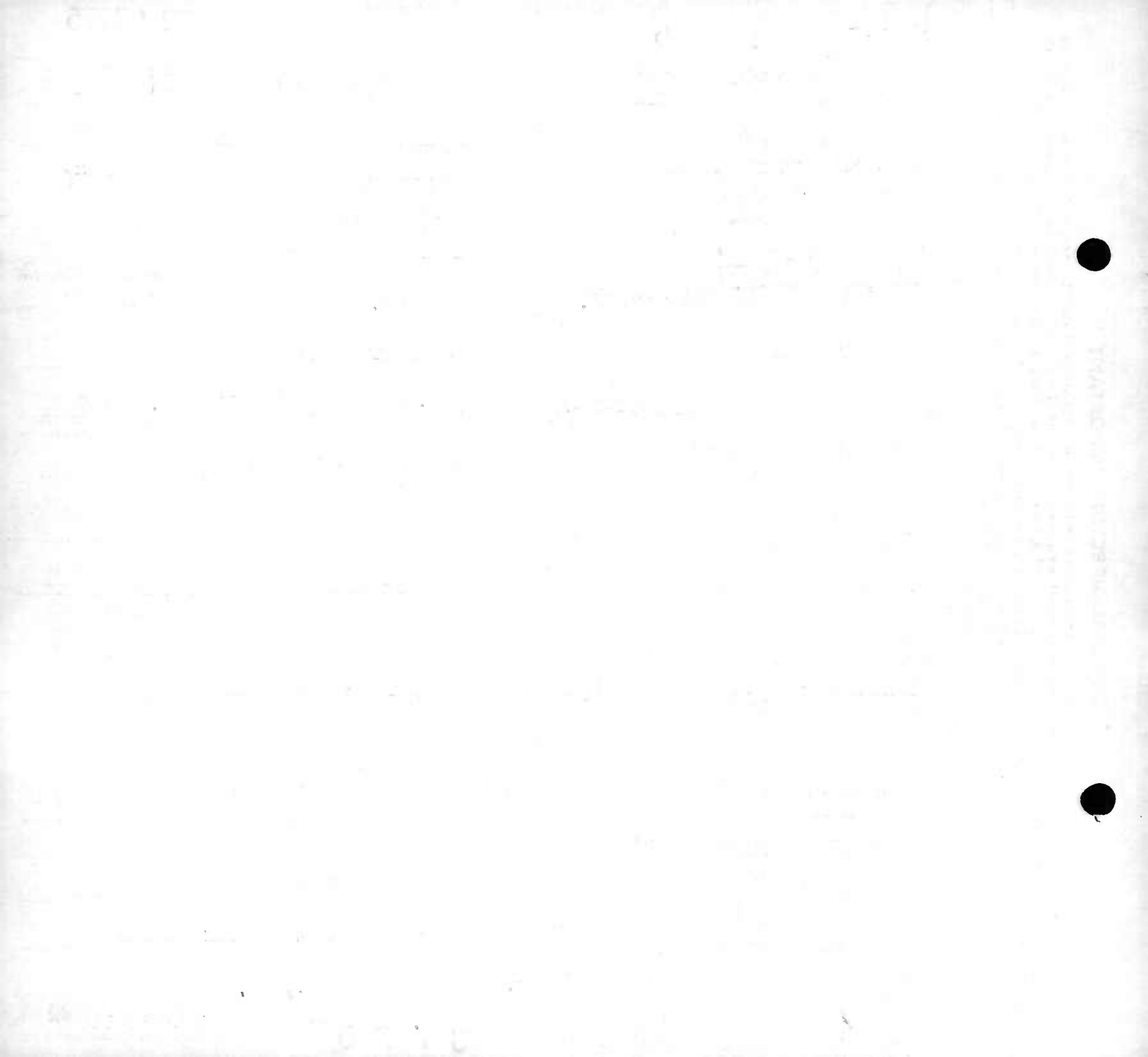
REG. NO.

1. NAME OF DECEASED (Type or Print) MATTIE MAE HARRIS		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 1121 Aisquith Street (1st fl.hallway)		3. DATE PRONOUNCED DEAD Month Day Year Hour April 14, 1972 8:00 P.M.	
6. SEX Female		7. RACE Negro	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore	
9. DATE OF BIRTH 10-20-16		10. AGE (in years lost birthday) 55 If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) Georgia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME ?		14. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY 1001	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Maids		14B. KIND OF BUSINESS OR INDUSTRY	
15. MOTHER'S MAIDEN NAME ?		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No	
17. SOCIAL SECURITY NO.		18. INFORMANT John W. Lauterbach-500 Semivale Ave.	
19. E 965 X1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		CAUSE OF DEATH Gunshot wound of chest (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C)	
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) yes			
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIB. <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Hallway	
22C. WHERE DID INJURY OCCUR? 1121 Aisquith Street 1001		22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.) 4-14-72 7:00 P.?	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? Found in hallway	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Ronald N. Kornblum, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
DATE SIGNED 4/15/72			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4/19/72	
24C. NAME OF CEMETERY or CREMATORY MT. Auburn Cem.		24D. LOCATION (City, town, or county) (State) Westport, Md.	
25A. DATE REC'D BY HEALTH DEPT APR 19 1972		25B. NAME OF REGISTRAR Robert E. Feltz, Jr.	
25C. FUNERAL DIRECTOR ELLIOTT FUNERAL HOME		ADDRESS	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

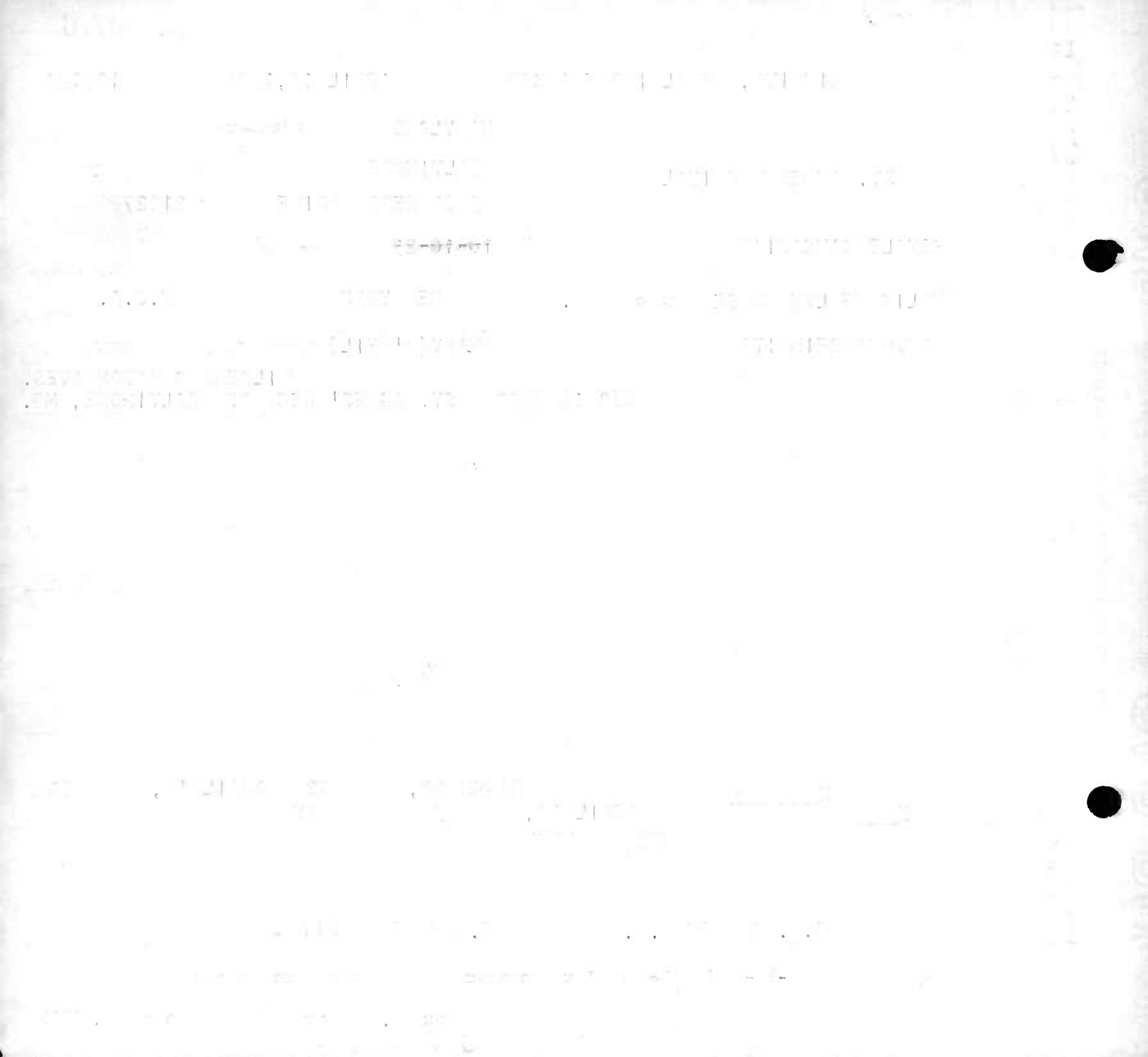
M-432		72 03775		BALTIMORE CITY HEALTH DEPARTMENT		X		REG. NO. 72 03775	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>Leonard Moltzer</i>				2. DATE AND HOUR OF DEATH <i>4/16/72 11:35 P. M.</i>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD						4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <i>THE JOHNS HOPKINS HOSPITAL</i> <i>BALTIMORE, MD 21205</i>						A. STATE <i>MARYLAND</i> B. COUNTY <i>BALTIMORE</i> C. CITY OR TOWN <i>BALTIMORE</i> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER <i>431 ACADEMY ROAD</i>			
5. SEX <i>FEMALE</i>	6. RACE <i>WHITE</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>10-22-09</i>	9. AGE (in years last birthday) <i>62</i>	10. Under 1 Yr. Months: Days: Hours: Min.		11. Under 24 Hrs. Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Seamstress</i>				10B. KIND OF BUSINESS OR INDUSTRY <i>Oak Loom Co.</i>		11. BIRTHPLACE (State or foreign country) <i>Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>WALTER BUTLER</i>						14. MOTHER'S MAIDEN NAME <i>CATHERINE FINN</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>				16. SOCIAL SECURITY NO. <i>553-34-0981</i>		17. INFORMANT ADDRESS <i>Mary B. Granger 1043 Cicks La. 21229</i>			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.						CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>cardio pulmonary arrest</i> (B) DUE TO, OR AS A CONSEQUENCE OF: <i>chronic grade III - L. parietal occipital region</i> (C) <i>Myocardial infarction</i>			
19. DATE OF OPERATION <i>4/12</i>						20A. AUTOPSY? (Yes or No) <i>NO</i>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (X) (this hospital) attended the deceased from <i>4/7</i> 19 <i>72</i> to <i>4/16</i> 19 <i>72</i> that (X) (we) last saw the deceased alive on <i>4/16</i> 19 <i>72</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <i>M. Sarkarati, M.D.</i>						23B. DATE SIGNED <i>4/16</i>		23C. PHYSICIAN'S NAME (Type) <i>MEHDI SARKARATI</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>						24B. DATE <i>4/20/72</i>		24C. NAME OF CEMETERY OR CREMATORY <i>Loudon Park Cem.</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>APR 19 1972</i>						25B. NAME OF REGISTRAR <i>Robert E. Taylor, M.D.</i>		25C. FUNERAL DIRECTOR ADDRESS <i>John T. Stangbury 6411 Windsor Mill Rd</i>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

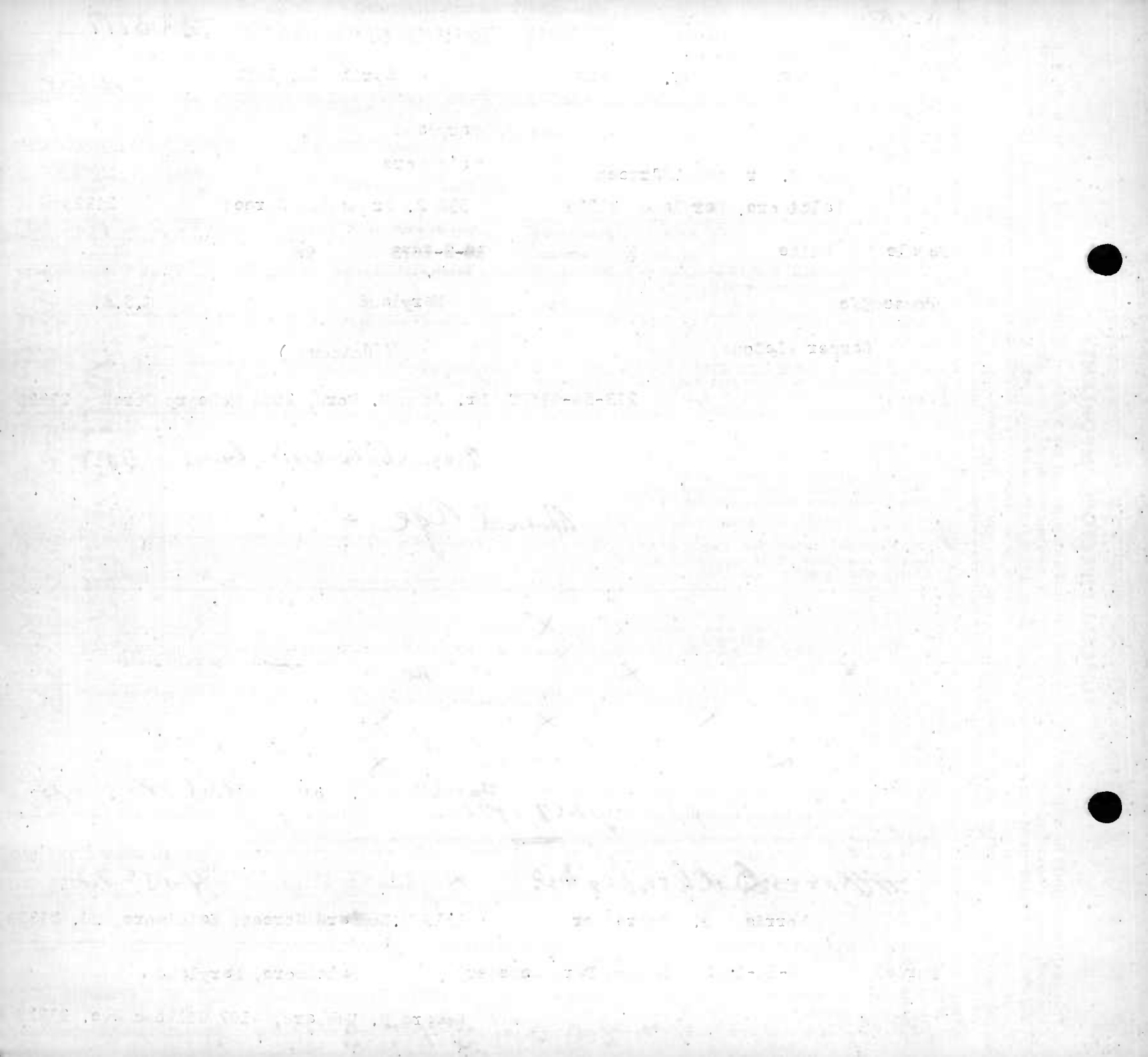
BALTIMORE CITY HEALTH DEPARTMENT				CERTIFICATE OF DEATH		REG. NO. 72 03776	
B-532 BIRTH NO. 72 03776				1. NAME OF DECEASED (Type or Print) REIMNITZ, GERALDINE FRANCES		2. DATE AND HOUR OF DEATH APRIL 15, 1972 11:15A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 40 ST. AGNES HOSPITAL				4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE MARYLAND B. COUNTY Baltimore C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER 5803 HERON DRIVE 21227			
5. SEX FEMALE		6. RACE CAUCASIAN		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10-10-23	
9. AGE (In years last birthday) 48		10. A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PUBLIC HEALTH NURSE		10B. KIND OF BUSINESS OR INDUSTRY State of Md.		11. BIRTHPLACE (State or foreign country) NEW YORK	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME ARTHUR REIMNITZ				14. MOTHER'S MAIDEN NAME MARY FRANCES O'NEILL	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO				16. SOCIAL SECURITY NO. 062 18 6873		17. INFORMANT WILKENS & CATON AVES. ST. AGNES' RECORDS BALTIMORE, MD.	
18. 174X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Metastatic Carcinoma ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Carcinoma Breast				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C)			
19. DATE OF OPERATION 0				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from MARCH 23, 1972 to APRIL 15, 1972 that <input checked="" type="checkbox"/> (we) last saw the deceased alive on APRIL 15, 1972 and that <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) (did) <input checked="" type="checkbox"/> view the body after death.							
23A. SIGNATURE C.R. Chaney				23B. DATE SIGNED 4/15/72		23C. PHYSICIAN'S NAME (Type) C.R. CHANEY M.D.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial				24B. DATE 4-19-1972		24C. NAME of CEMETERY or CREMATORY Loudon Park Cemetery	
25A. DATE REC'D BY HEALTH DEPT. APR 19 1972				25B. NAME OF REGISTRAR Howard H. Hubbard		25C. FUNERAL DIRECTOR Howard H. Hubbard, 4107 Wilkens Ave. 21229	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

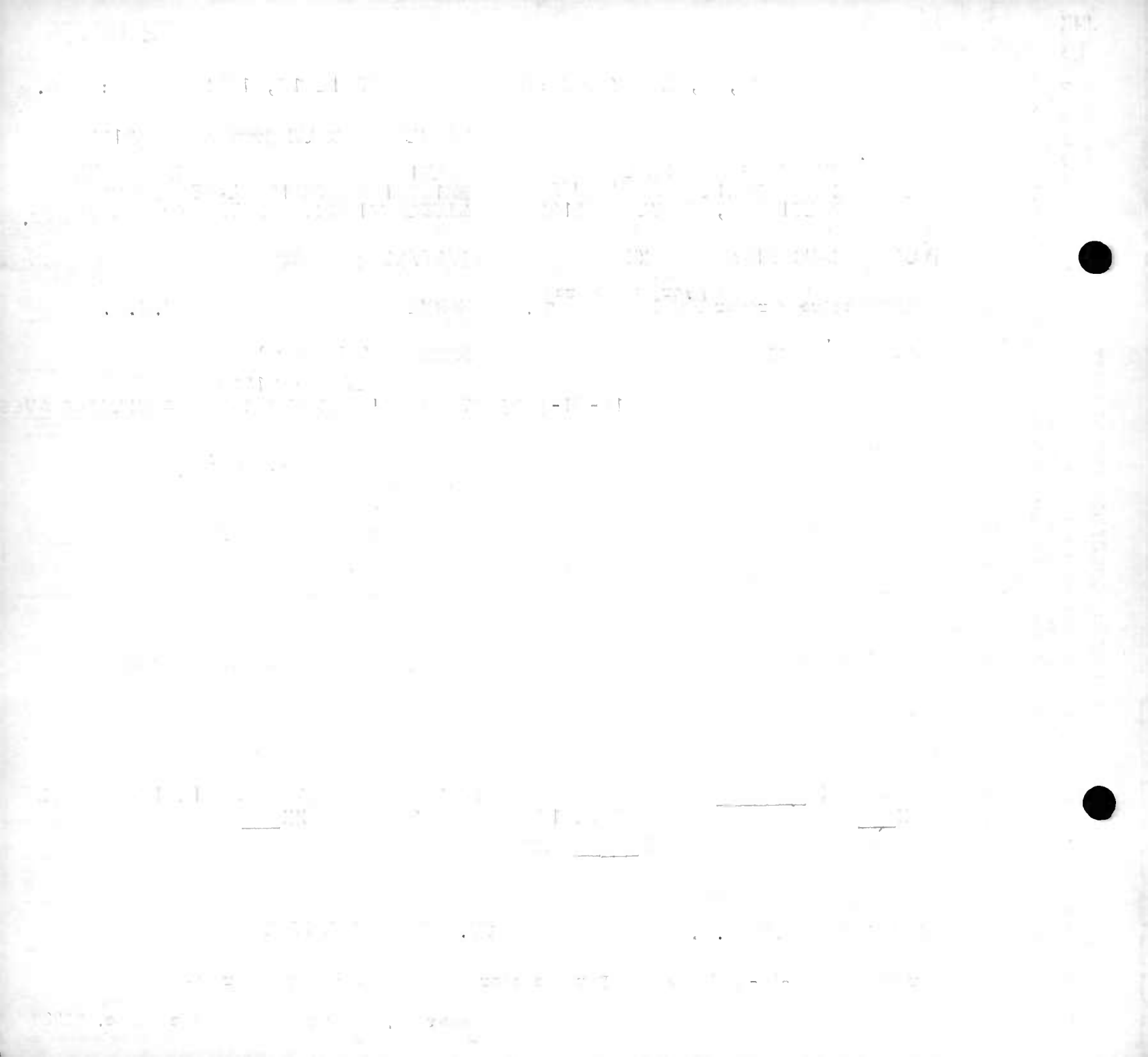
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>72 03777</u>	
CERTIFICATE OF DEATH					
BIRTH NO. <u>D-650</u>		1. NAME OF DECEASED <u>72 03777</u> <u>SARAH J. DORN</u>		2. DATE AND HOUR OF DEATH <u>April 14, 1972</u> <u>10:30 P M.</u>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>538 S. Brunswick Street</u> <u>Baltimore, Maryland 21223</u>			4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>2006</u> C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>538 S. Brunswick Street</u> <u>21223</u>		
5. SEX <u>Female</u>	6. RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-2-1873</u>	9. AGE (In years lost birthday) <u>98</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			13. FATHER'S NAME <u>Casper LeBon</u>		
14. MOTHER'S MAIDEN NAME <u>(Unknown)</u>			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		
16. SOCIAL SECURITY NO. <u>213-54-0377T</u>			17. INFORMANT ADDRESS <u>Mr. John N. Dorn, 2006 McHenry Street 21223</u>		
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>412.31</u> <u>Arteriosclerotic Heart Disease</u> <u>Advanced Age -</u>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs</u>		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <u>X</u>					
19A. DATE OF OPERATION <u>0</u> <u>X</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>X</u>		20A. AUTOPSY? (Yes or No) <u>No</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <u>X</u>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>X</u>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <u>X</u>	
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour) <u>X</u>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <u>X</u>	
22. I certify that (I) (this hospital) attended the deceased from <u>April 1960</u> to <u>April 14, 1972</u> , that (I) (we) lost saw the deceased alive on <u>April 7, 1972</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) <u>view</u> the body after death.					
23A. SIGNATURE <u>Morris B. Schreiber M.D.</u>				23B. DATE SIGNED <u>4-15-72</u>	
23C. PHYSICIAN'S NAME (Type) <u>Morris B. Schreiber</u>				23D. ADDRESS <u>1519 W. Lombard Street, Baltimore, Md. 21223</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>4-18-1972</u>		24C. NAME of CEMETERY or CREMATORY <u>Loudon Park Cemetery</u>	
24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>		25A. DATE REC'D BY HEALTH DEPT. <u>APR 19 1972</u>			
25B. NAME OF REGISTRAR <u>Robert E. Hubbard</u>		25C. FUNERAL DIRECTOR ADDRESS <u>Howard H. Hubbard, 4107 Wilkens Ave. 21229</u>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				CERTIFICATE OF DEATH		REG. NO. <u>72 03778</u>		
<p>BIRTH NO. <u>X-620</u></p> <p>1. NAME OF DECEASED (Type or Print) <u>KRAUS, SR., HENRY JOSEPH</u></p>		<p>2. DATE AND HOUR OF DEATH <u>APRIL 15, 1972</u> <u>6:00 A.M.</u></p>		<p>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</p>		<p>4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>BALTIMORE</u></p>		
<p>FULL NAME OF HOSPITAL OR INSTITUTION <u>ST AGNES HOSPITAL</u> <u>CATON & WILKENS AVENUES</u> <u>BALTIMORE, MARYLAND 21229</u></p>		<p>(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)</p>		<p>C. CITY OR TOWN <u>BALTIMORE</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input checked="" type="checkbox"/></p>		<p>E. STREET <u>FRANKLIN & HOWARD ST.</u></p>		
<p>5. SEX <u>MALE</u></p>	<p>6. RACE <u>CAUCASIAN</u></p>	<p>7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <u>WIDOWED</u> <input checked="" type="checkbox"/> <u>DIVORCED</u> <input type="checkbox"/></p>	<p>8. DATE OF BIRTH <u>03/20/82</u> <u>83</u></p>	<p>9. AGE (In years last birthday) <u>90</u> <u>89</u></p>	<p>If Under 1 Yr. Months <u> </u> Days <u> </u> If Under 24 Hrs. Hours <u> </u> Min. <u> </u></p>		<p>10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>WARD Retired Driver</u></p>	
<p>10B. KIND OF BUSINESS OR INDUSTRY <u>American Express Co.</u></p>		<p>11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u></p>		<p>12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u></p>		<p>13. FATHER'S NAME <u>H. JOSEPH KRAUS</u></p>		
<p>14. MOTHER'S MAIDEN NAME <u>XXXXX (Unknown)</u></p>		<p>15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u></p>		<p>16. SOCIAL SECURITY NO. <u>219-01-3023</u></p>		<p>17. INFORMANT <u>BALTO MD 21229</u> ADDRESS <u>ST AGNES' RECORDS CATON & WILKENS AVES</u></p>		
<p>18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>250.91</u></p>		<p>CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Myocardial infarction</u> (B) Generalized Arteriosclerosis (C) Diabetes Mellitus</p>		<p>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</p>		<p>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).</p>		
<p>19A. DATE OF OPERATION <u>0</u></p>		<p>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</p>		<p>20A. AUTOPSY? (Yes or No) <u>NO</u></p>		<p>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</p>		
<p>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/></p>		<p>21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)</p>		<p>21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)</p>		<p>21D. TIME OF INJURY (Month) (Day) (Year) (Hour) <u> </u> <u> </u> <u> </u> <u> </u></p>		
<p>21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/></p>		<p>21F. HOW DID INJURY OCCUR?</p>		<p>22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>MARCH 28</u> 19 <u>72</u> to <u>APRIL 15</u> 19 <u>72</u> that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>APRIL 15</u> 19 <u>72</u> and that in <input checked="" type="checkbox"/> (my) <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) (did) <input checked="" type="checkbox"/> (not) view the body after death.</p>		<p>23A. SIGNATURE <u>Joung Soon Lee M.D.</u> DEGREE</p>		
<p>23B. DATE SIGNED <u>4/15/72</u></p>		<p>23C. PHYSICIAN'S NAME (Type) <u>JOUNG SOON LEE M.D.</u> DEGREE</p>		<p>23D. ADDRESS <u>ST. AGNES HOSPITAL</u></p>		<p>23E. FUNERAL DIRECTOR <u>Howard H. Hubbard, 4107 Wilkens Ave. 21229</u> ADDRESS</p>		
<p>24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u></p>		<p>24B. DATE <u>4-17-1972</u></p>		<p>24C. NAME OF CEMETERY or CREMATORY <u>Loudon Park Cemetery</u></p>		<p>24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u></p>		
<p>25A. DATE REC'D BY HEALTH DEPT. <u>APR 19 1972</u></p>		<p>25B. NAME OF REGISTRAR <u>Rebecca Lee</u></p>		<p>25C. FUNERAL DIRECTOR <u>Howard H. Hubbard, 4107 Wilkens Ave. 21229</u></p>		<p>25D. ADDRESS</p>		



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				X		REG. NO. 72 03779	
BIRTH NO. 72 03779		72 03779		72 03779			
1. NAME OF DECEASED (Type or Print) JOSEPH EDGAR BLUNT				2. DATE AND HOUR OF DEATH APRIL 15, 1972 6:50 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) NORTH CHARLES HOSPITAL				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY BALTO. C. CITY OR TOWN PERRY HALL D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER 329 SILVERSPRING RD. 21128			
5. SEX M	6. RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-6-10	9. AGE On years last birthday 62	10. Under 1 Yr. Months Days	11. Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) STORES MAN		10B. KIND OF BUSINESS OR INDUSTRY CHEMICAL CO.		11. BIRTHPLACE (State or foreign country) MD.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JOSEPH V. BLUNT				14. MOTHER'S MAIDEN NAME SADIE MAY BLOUNT			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No ?		16. SOCIAL SECURITY NO. 217 01-5812		17. INFORMANT MEDICAL RECORDS		ADDRESS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				CAUSE OF DEATH METASTATIC CARCINOMA LIVER (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: FROM CA OF STOMACH ON PANCREAS (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 YR	
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 4-5-72 19 to 4-15-72 1972 that (I) (we) last saw the deceased alive on 4-15 1972 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Jacinto V. de Borja, M.D.				23B. DATE SIGNED 4-15-72			
23C. PHYSICIAN'S NAME (Type) JACINTO V. DE BORJA M.D.		23D. ADDRESS NORTH CHARLES GEN. HOSP.					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4/19/72		24C. NAME OF CEMETERY OR CREMATORY Ebenezer Cemetery		24D. LOCATION (City, town, or county) (State) Chase Balto. Md.	
25A. DATE REC'D BY HEALTH DEPT. APR 19 1972		25B. NAME OF REGISTRAR J. de Borja		25C. FUNERAL DIRECTOR Bassahn Funeral Home		ADDRESS 21236 7401 Belair Rd. Balto.	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

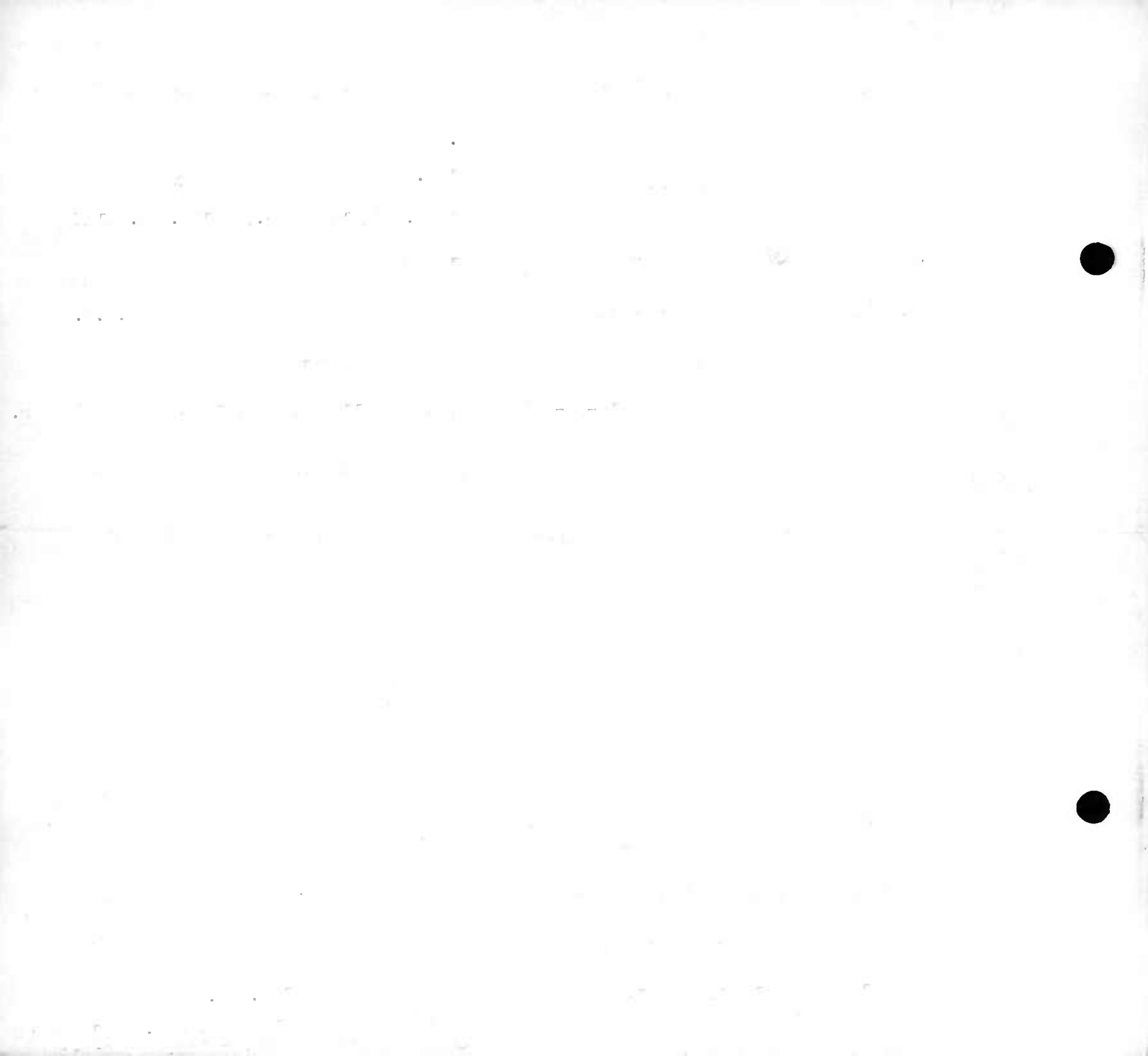
M-460		72 03780		BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		REG. NO. 72 03780	
1. NAME OF DECEASED (Type or Print) MILLER, MARIE B.		2. DATE AND HOUR OF DEATH 4-16-72 5:30 P.M.							
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) SINAI HOSPITAL		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MD. B. COUNTY BALTIMORE C. CITY OR TOWN PARKVILLE D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER 3037 PUTTY HILL AVE. #34							
5. SEX F	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 6-22-01		9. AGE (in years last birthday) 70		10. If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Seamstress		10B. KIND OF BUSINESS OR INDUSTRY Johnson Manufacturing Co.		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Jacob Dieter				14. MOTHER'S MAIDEN NAME Anna Luntz					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 215-10-2837		17. INFORMANT ADDRESS Mr. John A. Miller 4504 Ridge Rd. Balto. 21236					
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ADENOCARCINOMA OF THE COLON - METASTATIC		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 18 MO.							
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF:							
(C) DUE TO, OR AS A CONSEQUENCE OF:									
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).									
19A. DATE OF OPERATION 10/70		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED CARCINOMA OF COLON		20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? NO			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) NO		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (this hospital) attended the deceased from 4-14 19 72 to 4-16 19 72 that (we) last saw the deceased alive on 4-16 19 72 and that in (our) opinion death occurred on the date and hour and from the causes stated above. (I) (did) view the body after death.									
23A. SIGNATURE Ronald P. Byank, M.D.				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 4-16-72			
23C. PHYSICIAN'S NAME (Type) R. P. BYANK, M.D.				23D. ADDRESS SINAI HOSPITAL.					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4/19/72		24C. NAME OF CEMETERY OR CREMATORY Holy Redeemer Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore Md.			
25A. DATE REC'D BY HEALTH DEPT. APR 19 1972		25B. NAME OF REGISTRAR Debbie J. ...		25C. FUNERAL DIRECTOR Lassahn Funeral Home		ADDRESS 7401 Belair Rd. Balto. 21236			

EXHIBIT

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

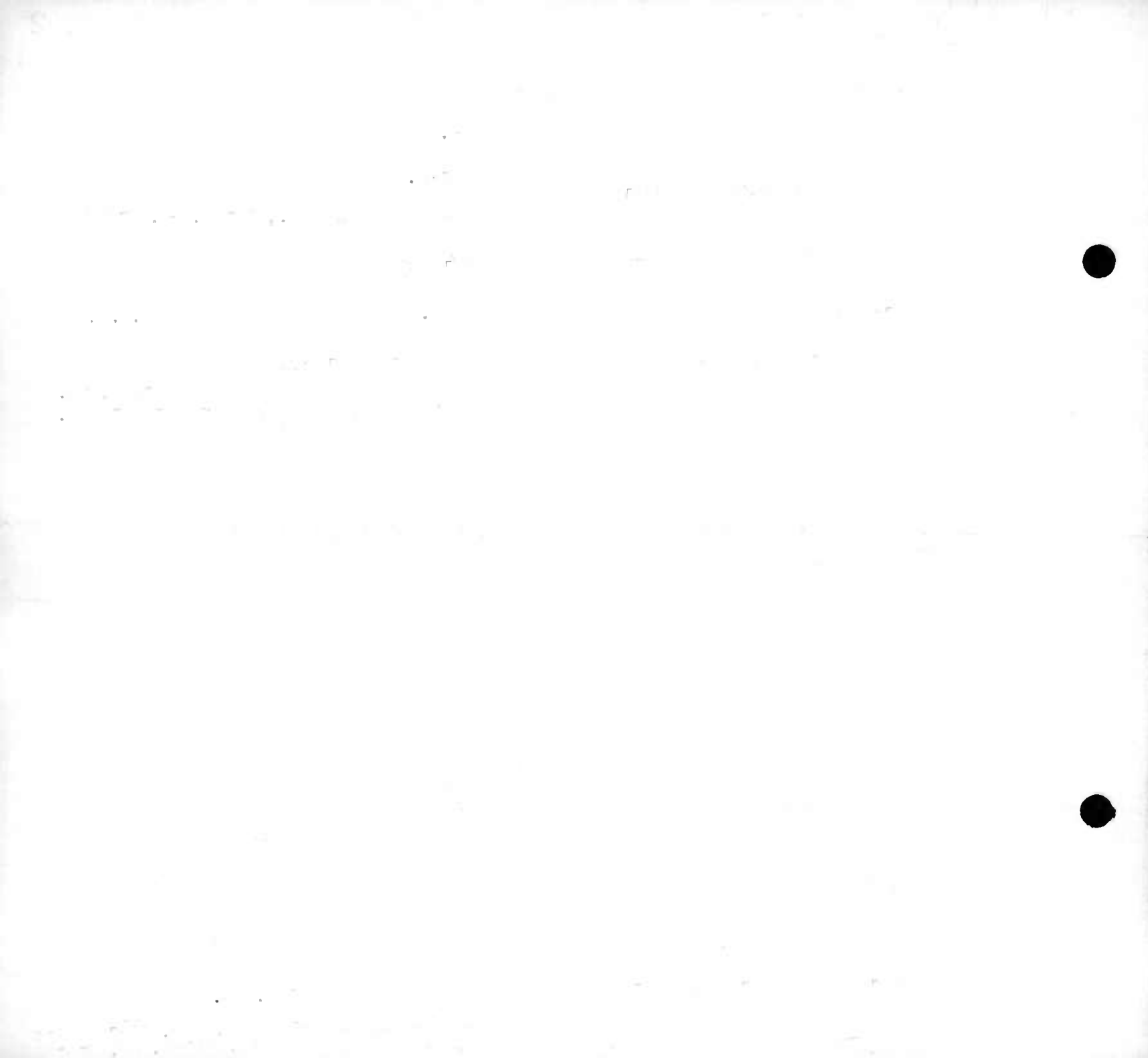
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 03781	
D-640 72 03781		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) DORL, VLASTA ANNA		2. DATE AND HOUR OF DEATH APRIL 14, 1972 2 45 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 90 Edgewood Nursing Home		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Md. B. COUNTY 2610 C. CITY OR TOWN Balto. D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 528 N. Highland Ave., Balto. Md. 21205			
5. SEX F	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8/13/86	9. AGE (In years last birthday) 85
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10B. KIND OF BUSINESS OR INDUSTRY at home		11. BIRTHPLACE (State or foreign country) Ohio	
12. CITIZEN OF WHAT COUNTRY U.S.A.		13. FATHER'S NAME Frank Cervenka			
14. MOTHER'S MAIDEN NAME Anna Kie1		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no			
16. SOCIAL SECURITY NO. 216-32-6232		17. INFORMANT ADDRESS Dorothy Mueller (dghtr) 1706 Greenspring Dr.			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) 4/12.4 I		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Cerebral thrombosis (B) Arteriosclerotic cardiovascular disease (C) ?		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 weeks	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) no	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Apr 6 1972 to Apr 14 1972 that (I) (we) last saw the deceased alive on Apr 13 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Frederick J. Vollmer MD				23B. DATE SIGNED 4-15-72	
23C. PHYSICIAN'S NAME (Type) FREDERICK J. VOLLMER MD		23D. ADDRESS 6100 York Rd Baltimore 21212			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4/17/72		24C. NAME OF CEMETERY OR CREMATORY Holy Redeemer Cemetery	
24D. LOCATION (City, town, or county) (State) Balto. Md.		25A. DATE REC'D BY HEALTH DEPT. APR 19 1972			
25B. NAME OF REGISTRAR John E. Taylor, Jr.		25C. FUNERAL DIRECTOR Schimunek Funeral Homes, Inc. 3331 Brehms Lane, Balto. Md. 21205			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>72 03782</u>	
1. NAME OF DECEASED (Type or Print) <u>ANTHONY WALTER DEMBECK</u>		2. DATE AND HOUR OF DEATH <u>4/13/72</u> <u>11</u> <u>P</u> M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <u>38 University Hospital</u>		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <u>Md.</u> B. COUNTY <u>2642</u>			
5. SEX <u>M</u>		6. RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Upholsterer</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>B & O RR</u>		8. DATE OF BIRTH <u>5/17/03</u>	
13. FATHER'S NAME <u>Walter Dembeck</u>		14. MOTHER'S MAIDEN NAME <u>Helen Welzant</u>		9. AGE (in years last birthday) <u>68</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO.		11. BIRTHPLACE (State or foreign country) <u>Md.</u>	
17. INFORMANT <u>Elaine Strozyk (dghtr) 601 Idlewild Rd.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. If means the disease, injury or complication which caused death.) <u>Ca Prostate</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last <u>Skeletal Metastases</u> <u>Uteral obstruction & anemia</u>	
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <u>II</u>					
19A. DATE OF OPERATION <u>4/6/72</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>NO</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>4/6/72</u> 19 to <u>4/13/72</u> 19 that (I) (we) last saw the deceased alive on <u>4/13/72</u> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>M. Chasin mo</u>				23B. DATE SIGNED <u>4/13/72</u>	
23C. PHYSICIAN'S NAME (Type) <u>MICHAEL ADAM CHASIN mo</u>				23D. ADDRESS <u>UNIV. mo. HOSP</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>4/17/72</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Holy Redeemer Cemetery</u>	
24D. LOCATION <u>Balto. Md.</u>		24E. DATE REC'D BY HEALTH DEPT. <u>APR 19 1972</u>		24F. NAME OF REGISTRAR <u>John E. Kelly, Jr.</u>	
24G. DATE REC'D BY HEALTH DEPT. <u>APR 19 1972</u>		24H. NAME OF REGISTRAR <u>John E. Kelly, Jr.</u>		24I. FUNERAL DIRECTOR <u>Schimunek Funeral Homes, Inc.</u>	
24J. ADDRESS <u>3331 Brehms Lane, Balto. Md.</u>		24K. ADDRESS <u>3331 Brehms Lane, Balto. Md.</u>		24L. ADDRESS <u>3331 Brehms Lane, Balto. Md.</u>	



VS 15-REV. 7/1/68

100 ST

100 ST

100 ST

100 ST

100 ST

100 ST

100 ST

100 ST

100 ST

100 ST

100 ST

100 ST

100 ST

100 ST

100 ST

100 ST

100 ST

100 ST

100 ST

100 ST

100 ST

100 ST

100 ST

100 ST

100 ST

100 ST

100 ST

1

B-655 72 03784 BALTIMORE CITY HEALTH DEPARTMENT
MEDICAL EXAMINER'S CERTIFICATE OF DEATH 72 03784

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Elizabeth G. Bowerman		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month 4 Day 18 Year 72 Hour 9:25 A. M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 44 Union Memorial Hospital		3. DATE PRONOUNCED DEAD Month 4 Day 18 Year 72 Hour 9:25 A. M.	
6. SEX Female		7. RACE White	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore	
9. DATE OF BIRTH 9-9-1894		10. AGE (In years last birthday) 77	
11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? USA	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		14B. KIND OF BUSINESS OR INDUSTRY Own Home	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		17. SOCIAL SECURITY NO.	
13. FATHER'S NAME Luke Kearney		15. MOTHER'S MAIDEN NAME Margaret Calley	
18. INFORMANT Mr. William J. Bowerman Sr		ADDRESS Same	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) E955X ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Home	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? 3707 Monterey Rd.		22F. HOW DID INJURY OCCUR? shot self in head	
22D. TIME (Month) (Day) (Year) (Hour) 4 18 72 8:15A		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Werner U. Spitz, M.D.		Deputy CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4-21-72	
24C. NAME OF CEMETERY or CREMATORY New Cathedral Cemetery		24D. LOCATION (City, town, or county) (State) Balto. Md.	
25A. DATE REC'D BY HEALTH DEPT. APR 19 1972		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.	
25C. FUNERAL DIRECTOR H. W. Jenkins & Sons Co.		ADDRESS 4905 York Road Balto., Md. 21212	

VS 151-REV. 1/1/68



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

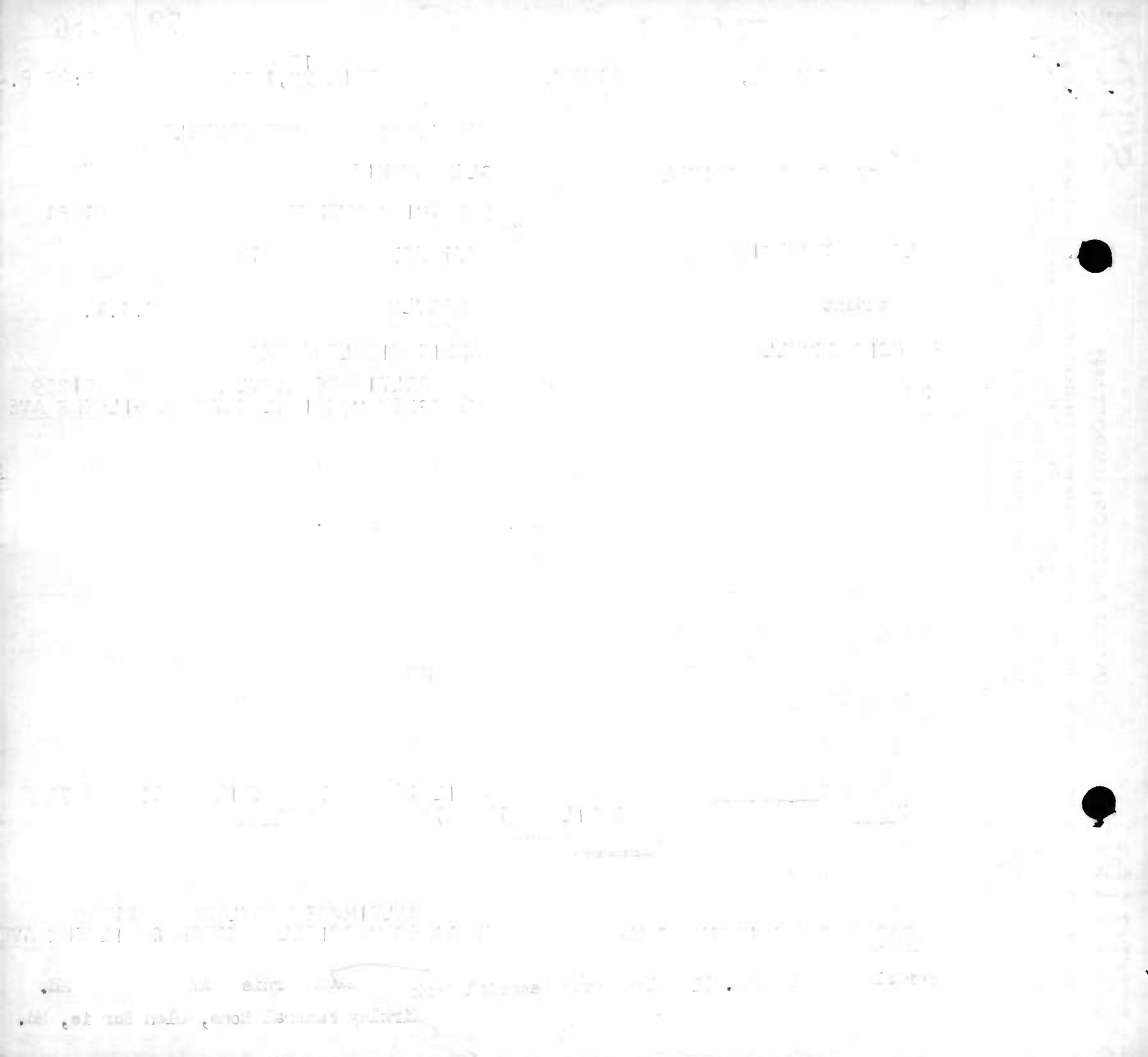
<div style="font-size: 2em; font-weight: bold;">S-530</div> <div style="font-size: 1.5em; font-weight: bold;">72 03785</div>		<div style="font-size: 1.2em; font-weight: bold;">BALTIMORE CITY HEALTH DEPARTMENT</div> <div style="font-size: 1.5em; font-weight: bold;">CERTIFICATE OF DEATH</div>		<div style="font-size: 1.2em; font-weight: bold;">REG. NO. 72 03785</div>	
<div style="font-size: 0.8em; font-weight: bold;">BIRTH NO.</div>		<div style="font-size: 0.8em; font-weight: bold;">1. NAME OF DECEASED</div> <div style="font-size: 0.8em;">(Type or Print)</div>		<div style="font-size: 0.8em; font-weight: bold;">2. DATE AND HOUR OF DEATH</div>	
		Edmund L. R. Smith		April 17, 1972 6:30 P.M.	
<div style="font-size: 0.8em; font-weight: bold;">3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</div>				<div style="font-size: 0.8em; font-weight: bold;">4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)</div>	
<div style="font-size: 0.8em; font-weight: bold;">FULL NAME OF HOSPITAL OR INSTITUTION</div> <div style="font-size: 0.8em;">(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)</div>				<div style="font-size: 0.8em; font-weight: bold;">A. STATE</div> <div style="font-size: 0.8em;">B. COUNTY</div>	
44 Union Memorial Hospital				Maryland 1201	
<div style="font-size: 0.8em; font-weight: bold;">5. SEX</div>		<div style="font-size: 0.8em; font-weight: bold;">6. RACE</div>		<div style="font-size: 0.8em; font-weight: bold;">7. MARRIED</div> <div style="font-size: 0.8em;">NEVER MARRIED</div> <div style="font-size: 0.8em;">WIDOWED</div> <div style="font-size: 0.8em;">DIVORCED</div>	
M		W		4-10-1897 75	
<div style="font-size: 0.8em; font-weight: bold;">10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)</div>		<div style="font-size: 0.8em; font-weight: bold;">10B. KIND OF BUSINESS OR INDUSTRY</div>		<div style="font-size: 0.8em; font-weight: bold;">11. BIRTHPLACE (State or foreign country)</div>	
Merchant		Self Employed Sales		Maryland	
<div style="font-size: 0.8em; font-weight: bold;">13. FATHER'S NAME</div>				<div style="font-size: 0.8em; font-weight: bold;">14. MOTHER'S MAIDEN NAME</div>	
Kirby Flower Smith				Charlotte P. Rodgers	
<div style="font-size: 0.8em; font-weight: bold;">15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown)</div>		<div style="font-size: 0.8em; font-weight: bold;">16. SOCIAL SECURITY NO.</div>		<div style="font-size: 0.8em; font-weight: bold;">17. INFORMANT</div>	
Yes		WWI		217-01-7139 A Mrs. Katherine N. Smith	
<div style="font-size: 0.8em; font-weight: bold;">18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</div> <div style="font-size: 0.8em;">(This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.)</div>				<div style="font-size: 0.8em; font-weight: bold;">CAUSE OF DEATH</div>	
<div style="font-size: 0.8em; font-weight: bold;">ANTECEDENT CAUSES</div> <div style="font-size: 0.8em;">DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.</div>				<div style="font-size: 0.8em; font-weight: bold;">APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</div>	
<div style="font-size: 0.8em; font-weight: bold;">OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).</div>				<div style="font-size: 0.8em; font-weight: bold;">(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:</div>	
<div style="font-size: 0.8em; font-weight: bold;">19A. DATE OF OPERATION</div>				<div style="font-size: 0.8em; font-weight: bold;">19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</div>	
<div style="font-size: 0.8em; font-weight: bold;">21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)</div>				<div style="font-size: 0.8em; font-weight: bold;">21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)</div>	
<div style="font-size: 0.8em; font-weight: bold;">21D. TIME OF INJURY (APPROX.)</div>				<div style="font-size: 0.8em; font-weight: bold;">21E. INJURY OCCURRED</div>	
<div style="font-size: 0.8em; font-weight: bold;">22. I certify that (I) (this hospital) attended the deceased from 7/1 1969 to 4/17 1972, that (I) (we) lost saw the deceased alive on 3/6 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</div>				<div style="font-size: 0.8em; font-weight: bold;">21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)</div>	
<div style="font-size: 0.8em; font-weight: bold;">23A. SIGNATURE</div>				<div style="font-size: 0.8em; font-weight: bold;">23B. DATE SIGNED</div>	
<div style="font-size: 0.8em; font-weight: bold;">23C. PHYSICIAN'S NAME (Type)</div>				<div style="font-size: 0.8em; font-weight: bold;">23D. ADDRESS</div>	
<div style="font-size: 0.8em; font-weight: bold;">24A. BURIAL CREMATION, REMOVAL (Specify)</div>				<div style="font-size: 0.8em; font-weight: bold;">24B. DATE</div>	
Burial				4-19-72	
<div style="font-size: 0.8em; font-weight: bold;">24C. NAME of CEMETERY or CREMATORY</div>				<div style="font-size: 0.8em; font-weight: bold;">24D. LOCATION (City, town, or county) (State)</div>	
Greenmount				Balto., Md.	
<div style="font-size: 0.8em; font-weight: bold;">25A. DATE REC'D BY HEALTH DEPT.</div>		<div style="font-size: 0.8em; font-weight: bold;">25B. NAME OF REGISTRAR</div>		<div style="font-size: 0.8em; font-weight: bold;">25C. FUNERAL DIRECTOR</div>	
APR 19 1972		Robert E. Jenkins		H. W. Jenkins & Sons Co. 4905 York Road Balto., Md. 21212	

MAK

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. S-400				72 03786		BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		72 03786		REG. NO.	
1. NAME OF DECEASED (Type or Print) SCHULL, ROBERT MICHAEL						2. DATE AND HOUR OF DEATH APRIL 16, 1972				3:45 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD						4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)							
FULL NAME OF HOSPITAL OR INSTITUTION 40 ST AGNES HOSPITAL						A. STATE MARYLAND						B. COUNTY ANNE ARUNDEL 5200	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)						C. CITY OR TOWN GLEN BURNIE				D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
						E. STREET AND NUMBER 303 THIRD AVENUE				21061			
5. SEX MALE		6. RACE CAUCASIAN		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 5/10/57		9. AGE (In years last birthday) 14		If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student				10B. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country) MARYLAND				12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME FRANCIS SCHULL						14. MOTHER'S MAIDEN NAME ANNIE MIDDLEBROOKS							
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO				16. SOCIAL SECURITY NO.		17. INFORMANT BALTIMORE MARYLAND				ADDRESS 21229			
						ST AGNES HOSPITAL CATON & WILKENS AVE							
18. 330.41 CAUSE OF DEATH												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)												2 day	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.												14 yrs	
(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Pneumonia													
(B) Muscular dystrophy DUE TO, OR AS A CONSEQUENCE OF:													
(C)													
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).													
19A. DATE OF OPERATION 0				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED				20A. AUTOPSY (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				21F. HOW DID INJURY OCCUR?					
22. I certify that (X) (this hospital) attended the deceased from APRIL 16 1972 to APRIL 17 1972 that (X) (we) last saw the deceased alive on APRIL 17 1972 and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) XXXXX view the body after death.													
23A. SIGNATURE Sasithorn Chittchang M.D.								DEGREE		23B. DATE SIGNED 4/17/72		23C. PHYSICIAN'S NAME (Type) SASITHORN CHITTCHANG MD	
23D. ADDRESS BALTIMORE MARYLAND 21229								ST AGNES HOSPITAL		CATON & WILKENS AVE			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial				24B. DATE 20 Apr. 72		24C. NAME of CEMETERY or CREMATORY Glen Haven Memorial Park				24D. LOCATION Glen Burnie AA		24E. STATE Md.	
25A. DATE REC'D BY HEALTH DEPT. APR 19 1972				25B. NAME OF REGISTRAR Kirkley				25C. FUNERAL DIRECTOR Kirkley Funeral Home, Glen Bur ie, Md.				ADDRESS	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

<div style="display: flex; justify-content: space-between;"> S-300 72 03787 BALTIMORE CITY HEALTH DEPARTMENT </div> <h2 style="text-align: center;">CERTIFICATE OF DEATH</h2>		REG. NO. 72 03787	
BIRTH NO. 1		2. DATE AND HOUR OF DEATH 4.12.1972 2:50 P.M.	
1. NAME OF DECEASED (Type or Print) ROBERT SCOTT		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland 8. COUNTY Baltimore C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 1501 Dukeland St.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 46 Lutheran Hospital Baltimore, Md. 21216		5. SEX M 6. RACE B 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH 6-7-91 9. AGE (in years lost birthday) 79 If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Virginia 12. CITIZEN OF WHAT COUNTRY U.S.A.	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 812-01-6409 17. INFORMANT MAE HARPER ADDRESS (Friend) 828 N. Bentalee St.	
18. 436.91 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE CARDIO-PULMONARY DUE TO, OR AS A CONSEQUENCE OF: FAILURE (B) Cerebro-Vascular DUE TO, OR AS A CONSEQUENCE OF: ACCIDENT (C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
19A. DATE OF OPERATION 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> 21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 4-3-1972 to 4-12-1972 that (I) (we) lost saw the deceased alive on 4-12-1972 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE Samuel J. Edwin MD 23C. PHYSICIAN'S NAME (Type)		23B. DATE SIGNED 4.12.72 23D. ADDRESS Lutheran Hospital 780 Ashburton St. Balto. Md. 21216	
24A. BURIAL CREMATION REMOVAL (Specify) Burial 24B. DATE 4-20-72 24C. NAME OF CEMETERY or CREMATORY Mt. Auburn Cemetery, Balto., Md. 24D. LOCATION (City, town, or county) (State)		25A. DATE REC'D BY HEALTH DEPT. APR 19 1972 25B. NAME OF REGISTRAR Robert E. J. ... 25C. FUNERAL DIRECTOR Meyer ... ADDRESS ... St.	

11/18/70

828 N. Bentonlow

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. <u>72 03788</u>
BIRTH NO. <u>0-520</u>		72 03788		
1. NAME OF DECEASED (Type or Print) <u>Gertrude Owens</u>		2. DATE AND HOUR OF DEATH <u>April 16, 1972</u> <u>7:20 A.M.</u>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>The Good Samaritan Hospital</u>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>1602</u> C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>1419 Mosher Street</u>		
5. SEX <u>F</u>	6. RACE <u>Negro</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5/5/15</u>	9. AGE (In years last birthday) <u>56</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>North Carolina, AURORA</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Mack Donaldson</u>		
14. MOTHER'S MAIDEN NAME <u>Sabra, Lillie Mae</u>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		
16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT <u>James Owens - 1419 Mosher St.</u>		
18. <u>303.21</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>Chronic renal failure</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>CHF 2° to alcoholic cardiomyopathy</u>		
(B) DUE TO, OR AS A CONSEQUENCE OF:		(C) _____		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from <u>JANUARY 22, 1972</u> to <u>April 16, 1972</u> that (I) (we) last saw the deceased alive on <u>April 15, 1972</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <u>George Curlin, M.D.</u>		23B. DATE SIGNED <u>4/16/72</u>		23C. PHYSICIAN'S NAME (Type) <u>George Curlin, M.D.</u>
23D. ADDRESS <u>Good Samaritan Hosp., Baltimore, Md.</u>		24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		
24B. DATE <u>4-20-72</u>		24C. NAME of CEMETERY or CREMATORY <u>Mt. Auburn Cemetery</u>		24D. LOCATION (City, town, or county) (State) <u>Balto, Md.</u>
25A. DATE REC'D BY HEALTH DEPT. <u>APR 19 1972</u>		25B. NAME OF REGISTRAR <u>Blair J. Jett</u>		25C. FUNERAL DIRECTOR <u>Morton J. Jett</u>
25D. ADDRESS <u>1701 Laurens St.</u>				

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

E-355 72 03789				BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 03789	
BIRTH NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) EDMONDSON, Claud Robert				2. DATE AND HOUR OF DEATH April 18, 1972 12:35 A. M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) U.S. PHS HOSPITAL				4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE Maryland B. COUNTY 1902 C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 1411 Holland Street <i>HOLLINS ST.</i>			
5. SEX Male	6. RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 8-3-1899	9. AGE (In years lost birthday) 72	If Under 1 Yr. Months Days	If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truck Driver		10B. KIND OF BUSINESS OR INDUSTRY <i>Freight Firm</i>		11. BIRTHPLACE (State or foreign country) Alabama		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Unknown			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) USArmy 1917 to 1922		16. SOCIAL SECURITY NO. 216 09 2614		17. INFORMANT ADDRESS Med. Records, US PHS HOSP, Balto., Md			
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) Respiratory failure ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Pneumonia Oat Cell carcinoma of lung						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 hours 7 days 5 Months	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).							
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (A) (this hospital) attended the deceased from 3-14 19 72 to 4-18 19 72 , that (A) (we) last saw the deceased alive on March 18 19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (A) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <i>Robert H. Kirschner</i>				23B. DATE SIGNED 4-18-72		23C. PHYSICIAN'S NAME (Type) Robert H. Kirschner, M.D.	
24A. BURIAL CREMATION, REMOVAL (Specify) burial		24B. DATE 4/21/72		24C. NAME OF CEMETERY or CREMATORY Glen Haven Cem.		24D. LOCATION (City, town, or county) (State) Glenburnie, Md.	
25A. DATE REC'D BY HEALTH DEPT. APR 20 1972		25B. NAME OF REGISTRAR Robert E. Fisher, R.D. 2		25C. FUNERAL DIRECTOR John J. Gough & Son, Inc.		25D. ADDRESS 901 Hollins St. Balto. 21223	

Page 4

Page 5

Page 6

Page 7

Page 8

Page 9

Page 10

Page 11

Page 12

Page 13

Page 14

Page 15

Page 16

Page 17

Page 18

Page 19

Page 20

Page 21

Page 22

Page 23

Page 24

Page 25

Page 26

Page 27

Page 28

Page 29

Page 30

Page 31

Page 32

Page 33

Page 34

Page 35

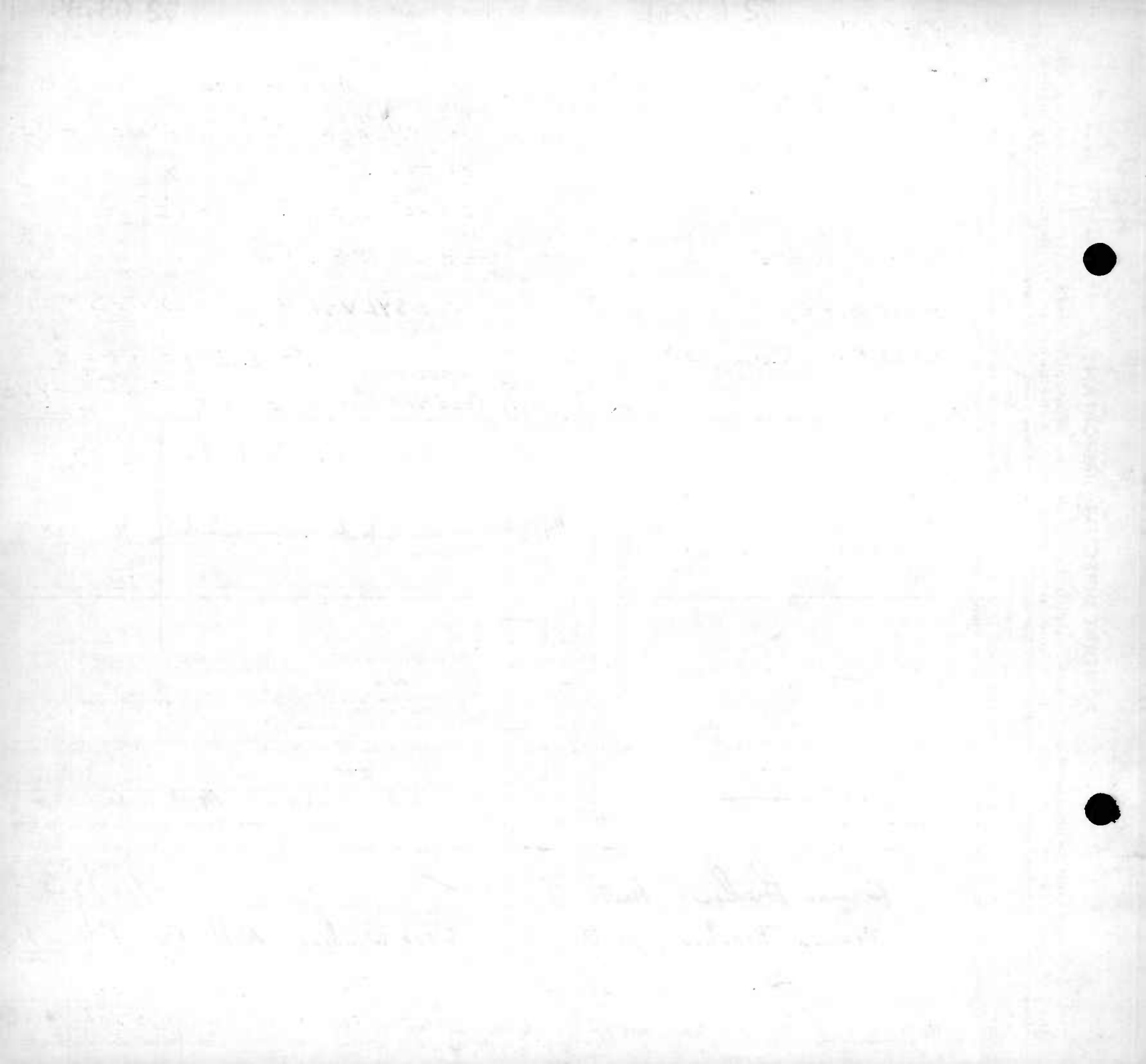
Page 36

Page 37

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

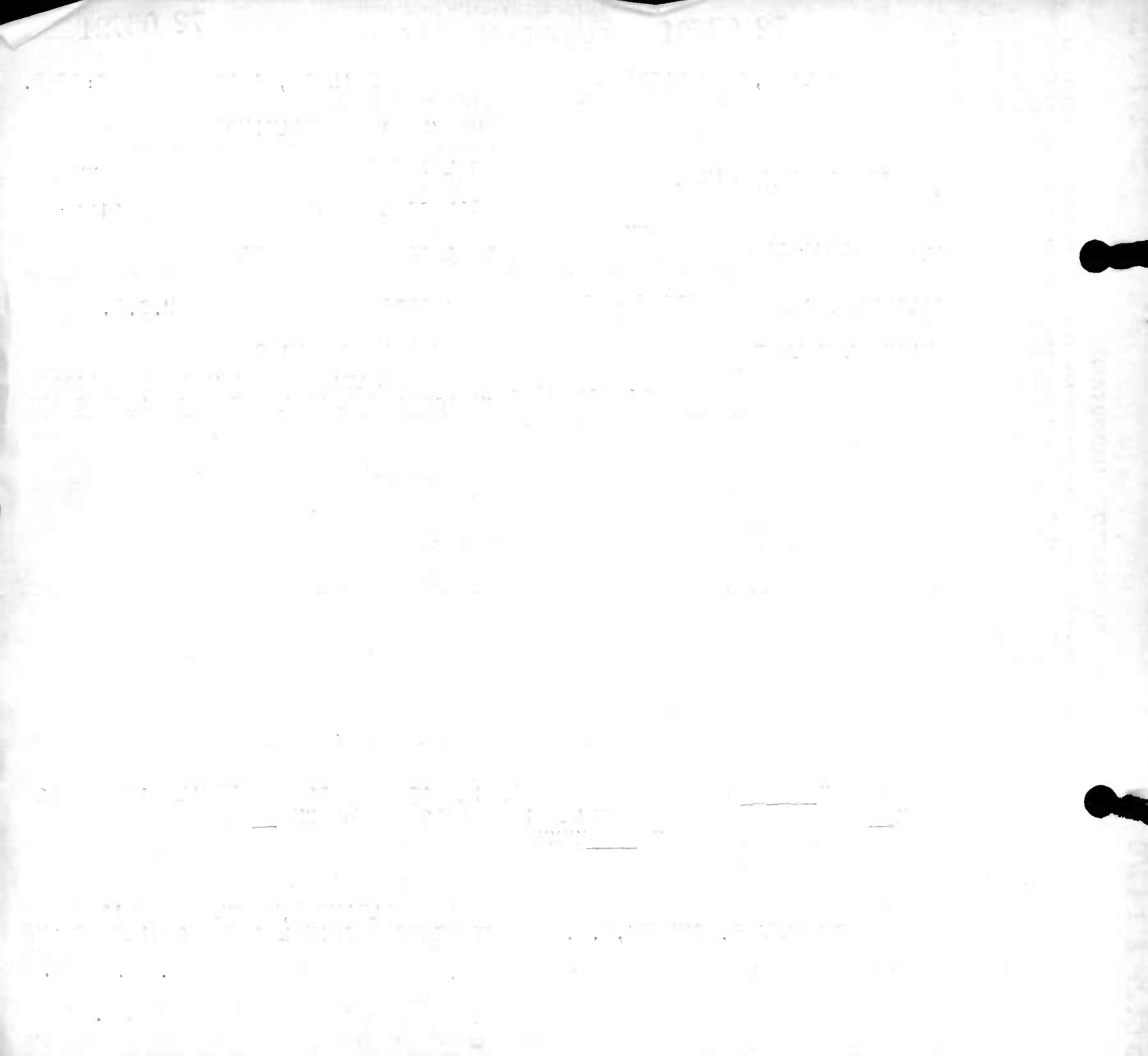
Baltimore City Health Department				REG. NO.	
<div style="display: flex; justify-content: space-between;"> B-260 72 03790 72 03790 </div>					
CERTIFICATE OF DEATH					
1. NAME OF DECEASED (Type or Print) MARY J Biser.			2. DATE AND HOUR OF DEATH April 18, 1972 4⁰⁰ A.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION 5505 Wayne Ave.			A. STATE MARYLAND B. COUNTY 3505 WAYNE AVE		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			C. CITY OR TOWN BALTO. CITY		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER 3505 WAYNE AVE 2802		
5. SEX FEMALE	6. RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH FEB 23, 1978	9. AGE (In years last birthday) 74	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10B. KIND OF BUSINESS OR INDUSTRY HOME		11. BIRTHPLACE (State or foreign country) PENNSYLVANIA	
12. CITIZEN OF WHAT COUNTRY? UNITED STATES		13. FATHER'S NAME JOSEPH SCHWAB			
14. MOTHER'S MAIDEN NAME STOLLENBURGER		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO. AB 170 036899		17. INFORMANT ADDRESS GLENN OMAR BISER 3505 WAYNE AVE			
18. 4100 I CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)			Acute Myocardial Infarction		
ANTECEDENT CAUSES			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.			(B) Hypertensive arteriosclerotic cardiovascular disease 16 yrs.		
			(C) _____		
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) No		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from November 19 69 to April 18 1972 , that (I) (we) last saw the deceased alive on April 17 19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Herman Brecher M.D.			23B. DATE SIGNED 4/18/72		23C. PHYSICIAN'S NAME (Type) Herman Brecher, M.D.
23D. ADDRESS 6410 Windsor Mill Rd. Baltimore Md.			23E. DATE REC'D BY HEALTH DEPT. APR 20 1972		
23F. NAME OF REGISTRAR Robert E. Jaber			23G. FUNERAL DIRECTOR JOHN T. STANSBURY		
23H. ADDRESS 6411 WINDSOR MILL RD. BALTO. MD.			23I. DATE OF BURIAL, CREMATION, REMOVAL (Specify) APRIL 21		
23J. NAME OF CEMETERY or CREMATORY WOODLAWN			23K. LOCATION (City, town, or county) (State) BALTO. MARYLAND		
23L. DATE REC'D BY HEALTH DEPT. APR 20 1972			23M. NAME OF REGISTRAR Robert E. Jaber		
23N. FUNERAL DIRECTOR JOHN T. STANSBURY			23O. ADDRESS 6411 WINDSOR MILL RD. BALTO. MD.		



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT														
V-452 72 03791					CERTIFICATE OF DEATH					REG. NO. 72 03791				
1. NAME OF DECEASED (Type or Print) VALMAS, JOHN MICHAEL					2. DATE AND HOUR OF DEATH APRIL 18, 1972 5:55 P.M.									
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD 40 ST AGNES HOSPITAL					4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE					5. STREET AND NUMBER 412 GRALAN ROAD 21228				
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 40 ST AGNES HOSPITAL					C. CITY OR TOWN BALTIMORE					D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
5. SEX MALE		6. RACE CAUCASIAN		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1/23/99		9. AGE (in years last birthday) 73		If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SELF EMPLOYED					10B. KIND OF BUSINESS OR INDUSTRY RESTAURANT					11. BIRTHPLACE (State or foreign country) GREECE				
12. CITIZEN OF WHAT COUNTRY? U.S.A.					13. FATHER'S NAME MICHAEL VALMAS					14. MOTHER'S MAIDEN NAME OURANIA KORAHIAS				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO					16. SOCIAL SECURITY NO. 219 32 0609					17. INFORMANT BALTIMORE MARYLAND 21229 ST AGNES HOSPITAL CATON & WILKENS AVE				
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH 600X I [This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.] Probable Myocardial Infarction										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH minutes				
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. urinary retention										DUE TO, OR AS A CONSEQUENCE OF: days				
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). B.P.H.										DUE TO, OR AS A CONSEQUENCE OF: yrs.				
19A. DATE OF OPERATION					19B. CONDITION FOR WHICH OPERATION WAS PERFORMED					20A. AUTOPSY? (Yes or No) NO				
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>					21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)					21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				
21F. HOW DID INJURY OCCUR?					22. I certify that (X) (this hospital) attended the deceased from APRIL 17 1972 to APRIL 18 1972 that (X) (we) last saw the deceased alive on APRIL 18 1972 and that (XX) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) did view the body after death.									
23A. SIGNATURE C. R. Chaney					23B. DATE SIGNED 4/18/72					23C. PHYSICIAN'S NAME (Type) CHARLES R. CHANEY, M.D.				
23D. ADDRESS BALTIMORE, MARYLAND 21229 ST AGNES HOSPITAL CATON & WILKENS AVE					24A. BURIAL CREMATION, REMOVAL (Specify) Burial					24B. DATE 4/21/72				
24C. NAME of CEMETERY or CREMATORY Greek Orthodox Cem.					24D. LOCATION (City, town, or county) (State) Woodlawn Balto. Co. Md.					25A. DATE RECD. IN HEALTH DEPT. APR 20 1972				
25B. NAME OF REGISTRAR James E. Chaney, Jr.					25C. FUNERAL DIRECTOR SLACK Funeral Home Ellicott City, Md. 21043					25D. ADDRESS 21043				



BIRTH NO.		REG. NO.	
1. NAME OF DECEASED (Type or Print) Lafayette Clarence/Law, Jr.		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> 4 18 72 1:10 A. M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Baltimore City Hospitals		3. DATE PRONOUNCED DEAD Month Day Year Hour 4 18 72 1:10 A. M.	
5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY BALTO		C. CITY OR TOWN Essex D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
6. SEX Male	7. RACE White	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH May 28, 1948		10. AGE (In years last birthday) 23 If Under 1 Yr. If Under 24 Hrs. Months; Days Hours Min.	
11. BIRTHPLACE (State or foreign country) Eastman, Georgia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Clarence L. Law, Sr.		14. MOTHER'S MAIDEN NAME Mary Elizabeth Dykes	
15. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Fireman		16. KIND OF BUSINESS OR INDUSTRY Balto. City	
17. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no		18. SOCIAL SECURITY NO. 213-46-2082	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) E 815.1 ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). II		20. IMMEDIATE CAUSE Multiple injuries DUE TO, OR AS A CONSEQUENCE OF: (B) _____ (C) _____	
21. DATE OF OPERATION 0		22. CONDITION FOR WHICH OPERATION WAS PERFORMED	
23. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		24. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Street	
25. TIME (Month) (Day) (Year) (Hour) (Approx.) 4 18 72 12:05 A. M.		26. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) Eastern Blvd, 252' W. of Ashley Rd.	
27. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		28. HOW DID INJURY OCCUR? passenger of auto which hit fixed object	
29. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Werner U. Spitz, M.D.		DATE SIGNED 4-18-72	
24A. BURIAL CREMATION, REMOVAL (Specify) Removal		24B. DATE Apr. 18, 1972	
24C. NAME OF CEMETERY or CREMATORY Stokes-Southerland Funeral Home, Eastman, Dodge Co., Georgia		24D. LOCATION (City, town, or county) (State)	
25A. DATE REC'D BY HEALTH DEPT. APR 20 1972		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.	
25C. FUNERAL DIRECTOR Howard K. McComas, Abingdon, Md.		ADDRESS	

ST. LOUIS

ST. LOUIS

ST. LOUIS

ST. LOUIS

ST. LOUIS

ST. LOUIS

ST. LOUIS

ST. LOUIS

ST. LOUIS

ST. LOUIS

ST. LOUIS

ST. LOUIS

ST. LOUIS

ST. LOUIS

ST. LOUIS

ST. LOUIS

ST. LOUIS

ST. LOUIS

ST. LOUIS

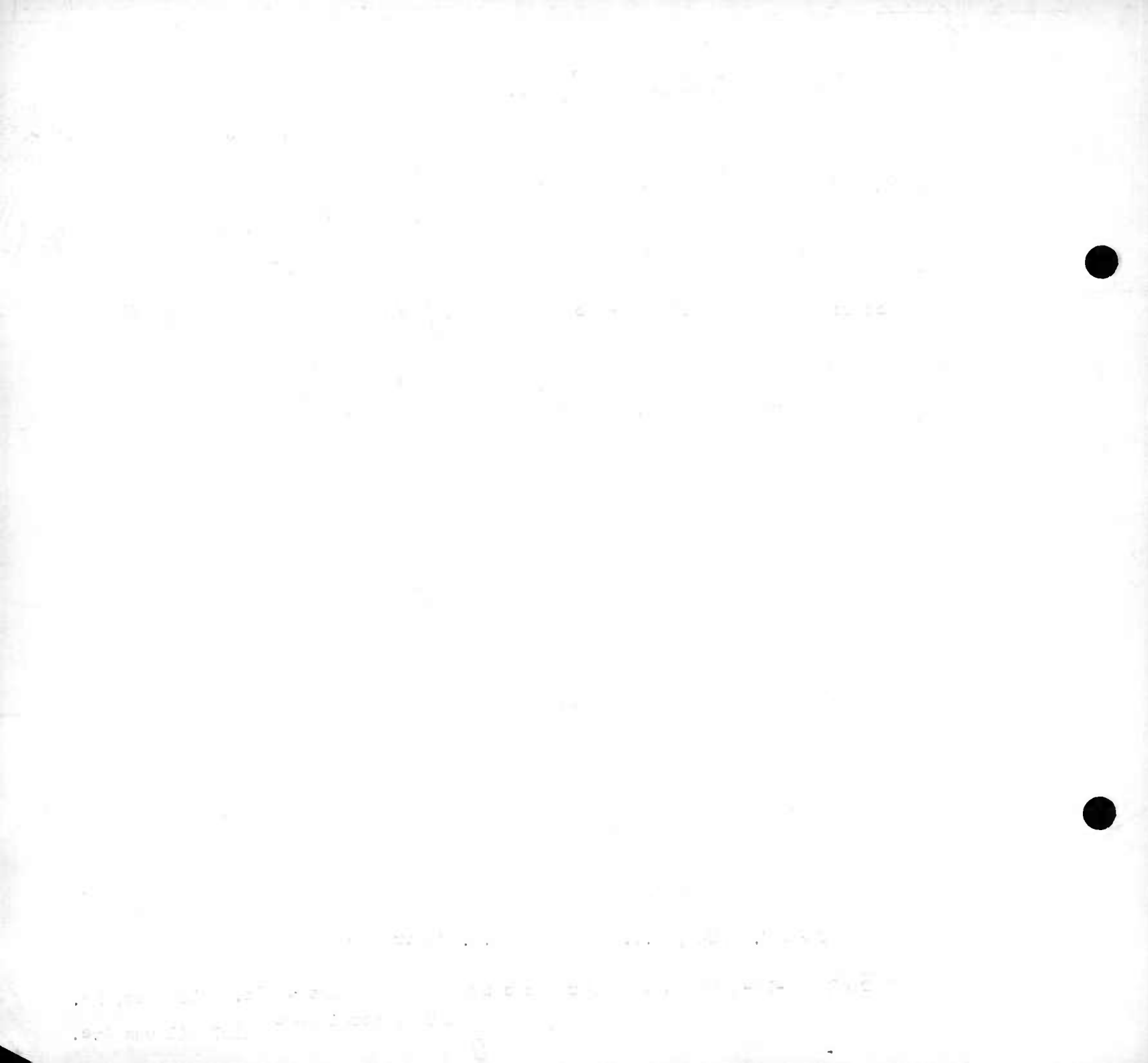
ST. LOUIS

ST. LOUIS

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

<p>K-000 72 03793</p> <p style="text-align: right;">BALTIMORE CITY HEALTH DEPARTMENT</p> <p style="text-align: center;">CERTIFICATE OF DEATH</p> <p style="text-align: right;">REG. NO. 72 03793</p>			
<p>1. NAME OF DECEASED (Type or Print) John Patrick Kehoe</p>		<p>2. DATE AND HOUR OF DEATH 4-17-72 10:30 P.</p>	
<p>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</p> <p>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) North Charles General Hospital</p>		<p>4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)</p> <p>A. STATE Maryland B. COUNTY BALTO</p> <p>C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/></p> <p>E. STREET AND NUMBER 4641 Wilkins Ave 21229</p>	
<p>5. SEX M</p>	<p>6. RACE W</p>	<p>7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/></p> <p>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/></p>	<p>8. DATE OF BIRTH 9-19-06</p>
<p>10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired</p>		<p>10B. KIND OF BUSINESS OR INDUSTRY Westinghouse</p>	<p>9. AGE (In years last birthday) 65</p> <p>11. BIRTHPLACE (State or foreign country) Canada</p>
<p>13. FATHER'S NAME John P. Kehoe</p>		<p>14. MOTHER'S MAIDEN NAME Mary S. Cuerrie</p>	
<p>15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No</p>		<p>16. SOCIAL SECURITY NO. A 125-05-0580</p>	<p>17. INFORMANT N.C.H. Hunt ADDRESS</p>
<p>18. CAUSE OF DEATH</p> <p>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</p> <p>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)</p> <p>ANTECEDENT CAUSES</p> <p>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p> <p style="text-align: center;">II</p> <p>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).</p>			<p>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</p>
<p>19A. DATE OF OPERATION 2-23-72</p>		<p>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Chr. Emphysema</p>	<p>20A. AUTOPSY? (Yes or No)</p>
<p>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Initially medical examiner)</p>		<p>21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)</p>	<p>21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)</p>
<p>21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)</p>		<p>21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/></p>	<p>21F. HOW DID INJURY OCCUR?</p>
<p>22. I certify that (I) (this hospital) attended the deceased from 2-22 1972 to 4-17 1972 that (I) (we) last saw the deceased alive on 4-17 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</p>			
<p>23A. SIGNATURE Jose G. Ortiz M.D.</p>		<p>23B. DATE SIGNED 4/17/72</p>	<p>23C. PHYSICIAN'S NAME (Type) Jose G. Ortiz, M.D.</p>
<p>23D. ADDRESS N.C. General Hospital</p>		<p>23E. DEGREE</p>	
<p>24A. BURIAL CREMATION REMOVAL Burial</p>	<p>24B. DATE 4-21-1972</p>	<p>24C. NAME of CEMETERY or CREMATORY Loudon Park Cemetery</p>	<p>24D. LOCATION (City, town, or county) (State) Wilkins Ave. Baltimore, Md.</p>
<p>25A. DATE REC'D BY HEALTH DEPT. APR 20 1972</p>	<p>25B. NAME OF REGISTRAR Hubbard Funeral Home</p>	<p>25C. ADDRESS 4107 Wilkins Ave.</p>	



72 03794

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

72 03794

BIRTH NO.

1. NAME OF DECEASED (Type or Print) HERMAN JEFFRIES		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) MARYLAND GENERAL HOSPITAL		3. DATE PRONOUNCED DEAD Month Day Year Hour April 18, 1972 12:20 P.M.	
5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY 11002			
6. SEX Male	7. RACE Negro	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
9. DATE OF BIRTH 7-4-14	10. AGE (In years lost birthday) 57	E. STREET AND NUMBER 1129 Woodyear Street	
11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF U.S.A.	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		15. MOTHER'S MAIDEN NAME Ella Neal	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give year or dates of service) yes 1944-1946		17. SOCIAL SECURITY NO.	
18. INFORMANT Mildred Jackson		ADDRESS 3312 W. North Ave.	
19. 3-7-18 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Bronchopneumonia		CAUSE OF DEATH Bronchopneumonia APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Fatty metamorphosis of Liver (B) DUE TO, OR AS A CONSEQUENCE OF: (C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
20A. DATE OF OPERATION 2	20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) yes
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
22D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)	22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Ronald N. Kornblum M.D. EXAMINER'S NAME (Type) Ronald N. Kornblum, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 4/19/72			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 4-21-72	24C. NAME OF CEMETERY or CREMATORY Arbutus Mem. Park	24D. LOCATION (City, town, or county) (State) Baltimore, Md.
25A. DATE REC'D BY HEALTH DEPT. APR 20 1972	25B. NAME OF REGISTRAR Robert E. Bailey, M.D.	25C. FUNERAL DIRECTOR V. Bailey ADDRESS Kelson F. H. 1348 Calhoun Street	

1070 S

1070 S

1070 S

1070 S

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

C-462		72 03795		BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		REG. NO. 72 03795	
BIRTH NO.				1. NAME OF DECEASED (Type or Print) CLARKE DAISY				2. DATE AND HOUR OF DEATH APRIL 18, 1972 3:00 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) BALTIMORE CITY HOSP. BALTIMORE, Md 21224				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE				C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX FEMALE		6. RACE NEGRO		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10/29/89		9. AGE (In years last birthday) 72	
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE				10B. KIND OF BUSINESS OR INDUSTRY NONE		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS BCH RECORDS: 4940 Eastern Avenue 21224			
18. 593.2 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH Cardiopulmonary Arrest (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Aspirated Pneumonia (B) DUE TO, OR AS A CONSEQUENCE OF: Renal failure (C)				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 hrs 2 hrs 2 hrs.	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).									
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from 1/14/1972 to 4/18/1972 that (I) (we) last saw the deceased alive on 4/18/1972 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE Surat Sinasa M.D.				23B. DATE SIGNED 4/18/72					
23C. PHYSICIAN'S NAME (Type) SURAT SINASA M.D.		23D. ADDRESS Baltimore City Hosp, Baltimore, Md							
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4/22/72		24C. NAME OF CEMETERY or CREMATORY Mt Auburn Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Md			
25A. DATE REC'D BY HEALTH DEPT APR 20 1972		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR A Halstead		ADDRESS 1206 W North Ave			

A Halstead 1206 W North Ave
Baltimore, Md
4/22/72
Burial

MT Auburn Cemetery

Maryland

75 3750

75 63700

12 00185

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>72 03796</u>	
<p><u>S-535</u> <u>72 03796</u></p> <p>BIRTH NO. <u>72 03796</u></p> <p>1. NAME OF DECEASED (Type or Print) <u>Joan Theresa Snowden</u></p>		<p>CERTIFICATE OF DEATH</p>			
<p>2. DATE AND HOUR OF DEATH <u>4/17/72</u> <u>18:15</u> P. M.</p>		<p>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</p> <p>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>Univ. of Maryland</u></p>			
<p>4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)</p> <p>A. STATE <u>Maryland</u></p> <p>C. CITY OR TOWN <u>Baltimore</u></p> <p>D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></p> <p>E. STREET AND NUMBER <u>605 Pierce Street</u></p>		<p>5. SEX <u>F</u></p> <p>6. RACE <u>B</u></p> <p>7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/></p> <p>8. DATE OF BIRTH <u>12/8/34</u></p> <p>9. AGE (In years last birthday) <u>37</u></p> <p>10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Welfare</u></p> <p>10B. KIND OF BUSINESS OR INDUSTRY</p> <p>11. BIRTHPLACE (State or foreign country) <u>Washington D C</u></p> <p>12. CITIZEN OF WHAT COUNTRY? <u>U S A</u></p>			
<p>13. FATHER'S NAME <u>Louis Snowden</u></p> <p>15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)</p>		<p>14. MOTHER'S MAIDEN NAME <u>Meriam Waters</u></p> <p>16. SOCIAL SECURITY NO.</p> <p>17. INFORMANT ADDRESS <u>Mrs Meriam Waters, 718 N Carey St</u></p>			
<p>18. <u>427.21</u></p> <p>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</p> <p>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)</p> <p>ANTECEDENT CAUSES</p> <p>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p>		<p>CAUSE OF DEATH</p> <p>(A) IMMEDIATE CAUSE <u>Probable Septic Shock</u></p> <p>DUE TO, OR AS A CONSEQUENCE OF:</p> <p>(B) <u>aspiration Pneumonitis</u></p> <p>DUE TO, OR AS A CONSEQUENCE OF:</p> <p>(C) <u>Seizure → Cardiac arrest</u></p> <p>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</p> <p><u>8 hours</u></p> <p><u>12 hrs</u></p> <p><u>-12-13 hrs</u></p>			
<p>II</p> <p>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).</p>					
<p>19A. DATE OF OPERATION <u>2</u></p> <p>21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)</p> <p>21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)</p>		<p>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</p> <p>21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)</p> <p>21E. INJURY OCCURRED</p> <p>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/></p>		<p>20A. AUTOPSY? (Yes or No) <u>Yes</u></p> <p>21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)</p> <p>21F. HOW DID INJURY OCCUR?</p>	
<p>22. I certify that <u>(I)</u> (this hospital) attended the deceased from <u>4/17</u> <u>19 72</u> to <u>4/17</u> <u>19 72</u> that <u>(I/we)</u> last saw the deceased alive on <u>4/17</u> <u>19 72</u> and that <u>in (my)</u> (our) opinion death occurred on the date and hour and from the causes stated above. <u>(I)</u> (We) (did) (did not) view the body after death.</p>					
<p>23A. SIGNATURE <u>Richard A. Tomasulo M.D.</u></p> <p>23C. PHYSICIAN'S NAME (Type) <u>Richard A. Tomasulo M.D.</u></p>		<p>23B. DATE SIGNED <u>4/17/72</u></p> <p>23D. ADDRESS <u>Univ. of Md Hosp.</u></p>		<p>24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u></p> <p>24B. DATE <u>4/21/72</u></p> <p>24C. NAME OF CEMETERY OR CREMATORY <u>MT. Calvary Cemetery</u></p> <p>24D. LOCATION (City, town, or county) (State) <u>A A County Md</u></p>	
<p>25A. DATE REC'D BY HEALTH DEPT. <u>APR 20 1972</u></p>		<p>25B. NAME OF REGISTRAR <u>Robert E. Taylor, M.D.</u></p>		<p>25C. FUNERAL DIRECTOR <u>Halstead</u> ADDRESS <u>1206 W North Ave</u></p>	

burial 4/21/72 MT Calvary Cemetery A A County Md
Halstead 1206 W North Ave A

BALTIMORE CITY HEALTH DEPARTMENT				MEDICAL EXAMINER'S CERTIFICATE OF DEATH				REG. NO. 72 03797			
1. NAME OF DECEASED (Type or Print) ALVIS TRANSOU				2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> April 13, 1972				3. DATE OF DEATH Month Day Year April 13, 1972 9:15 A.			
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION Sinai Hospital (DOA)				5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY 802							
6. SEX Male		7. RACE Negro		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
9. DATE OF BIRTH 8-29-1936		10. AGE (In years lost birthday) 35		11. BIRTHPLACE (State or foreign country) DAVIDSON CO NC		12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME ALVIS J. TRANSOU			
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) London & Body Man - AUTO				14B. KIND OF BUSINESS OR INDUSTRY				15. MOTHER'S MAIDEN NAME TOROTHA ADAMS			
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)				17. SOCIAL SECURITY NO. 216-32-4230		18. INFORMANT TOROTHA TRANSOU				ADDRESS 1034 Broomfield Ave	
19. CAUSE OF DEATH 571.8 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 7				20B. CONDITION FOR WHICH OPERATION WAS PERFORMED				21. AUTOPSY? (Yes or No) (Partial) Yes			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?			
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> (Partial)				22F. HOW DID INJURY OCCUR?			
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Charles S. Springate M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) Charles S. Springate, M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> April 13, 1972											
24A. BURIAL CREMATION, REMOVAL (Specify) Burned				24B. DATE 4/22/72		24C. NAME OF CEMETERY or CREMATORY MT Calvary		24D. LOCATION (City, town, or county) (State) Glen Burnie MD			
25A. DATE REC'D BY HEALTH DEPT. APR 20 1972				25B. NAME OF REGISTRAR Robert E. Taylor M.D.				25C. FUNERAL DIRECTOR Mary Ann P. Hays ADDRESS 6383 91st Ave St			

10.10.57

10.10.57

10.10.57

R-200

72 03798

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

72-03798

BIRTH NO.

1. NAME OF DECEASED

(Type or Print)

(Alonzo) (A LONZO) REESE

2. DATE
OF
DEATHKnown ☒ Estimated ☐Month
Day
YearMonth
Day
Year

Hour

12:25 P.M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL
OR INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

Bon Secours Hospital

3. DATE
PRONOUNCED DEADMonth
Day
YearMonth
Day
Year

Hour

12:25 P.M.

5. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)

A. STATE

B. COUNTY

Maryland

C. CITY OR TOWN

D. INSIDE CITY LIMITS?

Baltimore

YES ☒NO ☐

6. SEX

Male

7. RACE

Negro

8. MARRIED ☒NEVER MARRIED ☐WIDOWED ☐DIVORCED ☐

9. DATE OF BIRTH

May 5, 1920

10. AGE (In years
last birthday)

51

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

E. STREET AND NUMBER

203 N. Carey Street

11. BIRTHPLACE (State or foreign country)

La Grange, Ga.

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Alonzo Reese

14A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

Vira Newton

16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

17. SOCIAL
SECURITY NO.

257-07-3808

18. INFORMANT

ADDRESS

Curita Reese, 203 North Carey Street

19. E 814.7

CAUSE OF DEATH

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) IMMEDIATE CAUSE Multiple injuries
DUE TO, OR AS A CONSEQUENCE OF:

(B) DUE TO, OR AS A CONSEQUENCE OF:

(C) DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART 1 (A).

20A. DATE OF OPERATION 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

Yes

22A. EXTERNAL CAUSE WAS
UNDERLYING ☒ OR CONTRIB-
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg., etc.)

Street

22C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?

Fayette St. 56' W. of Schroeder St.

22D. TIME (Month) (Day) (Year) (Hour)
OF INJURY (APPROX.) 4 3 72 12:15
P. M.22E. INJURY OCCURRED
WHILE AT WORK ☐ NOT WHILE
AT WORK ☒

22F. HOW DID INJURY OCCUR?

Pedestrian struck by ~~auto~~ auto

23.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Werner H. Spitz, M.D.

Deputy

CHIEF MEDICAL EXAMINER ☒ASSISTANT MEDICAL EXAMINER ☐ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

4-4-72

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

4/8/72

24C. NAME OF CEMETERY or CREMATORY

Eastview Cemetery

24D. LOCATION (City, town, or county)

(State)

La Grange, Ga.

25A. DATE REC'D BY HEALTH DEPT.

25B. NAME OF REGISTRAR

25C. FUNERAL DIRECTOR

ADDRESS

Wilson F.H. 507 E. Depot St.

7 La Grange, Ga.

25-10-57

10. 15 (10-11)

10. 15 (10-11)

10. 15 (10-11)

10. 15 (10-11)

10. 15 (10-11)

10. 15 (10-11)

10. 15 (10-11)

10. 15 (10-11)

10. 15 (10-11)

WALLINGFORD

WALLINGFORD

10. 15 (10-11)

10. 15 (10-11)

10. 15 (10-11)

10. 15 (10-11)

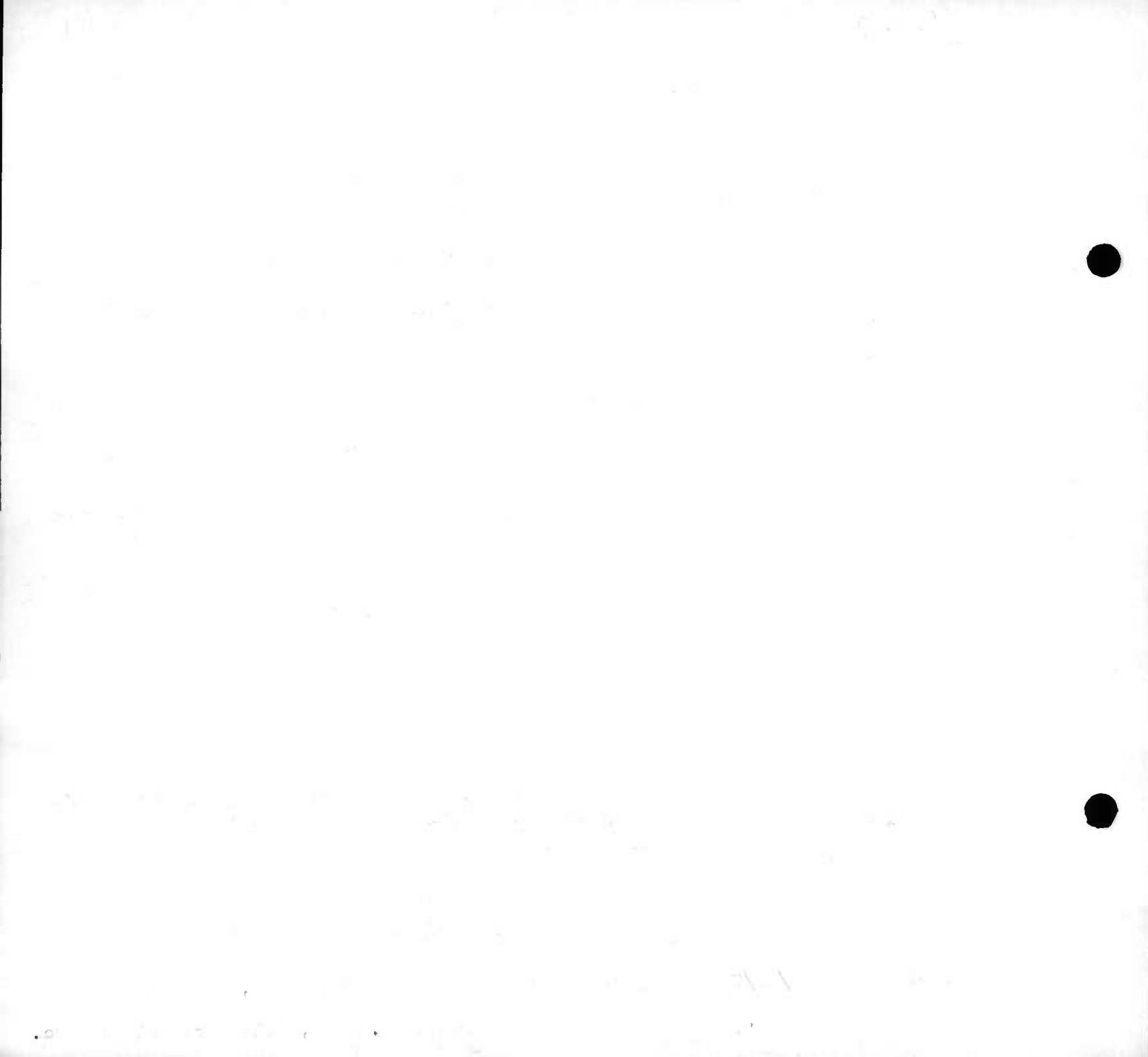
10. 15 (10-11)

10. 15 (10-11)

FUNERAL DIRECTOR: IMPORTANT

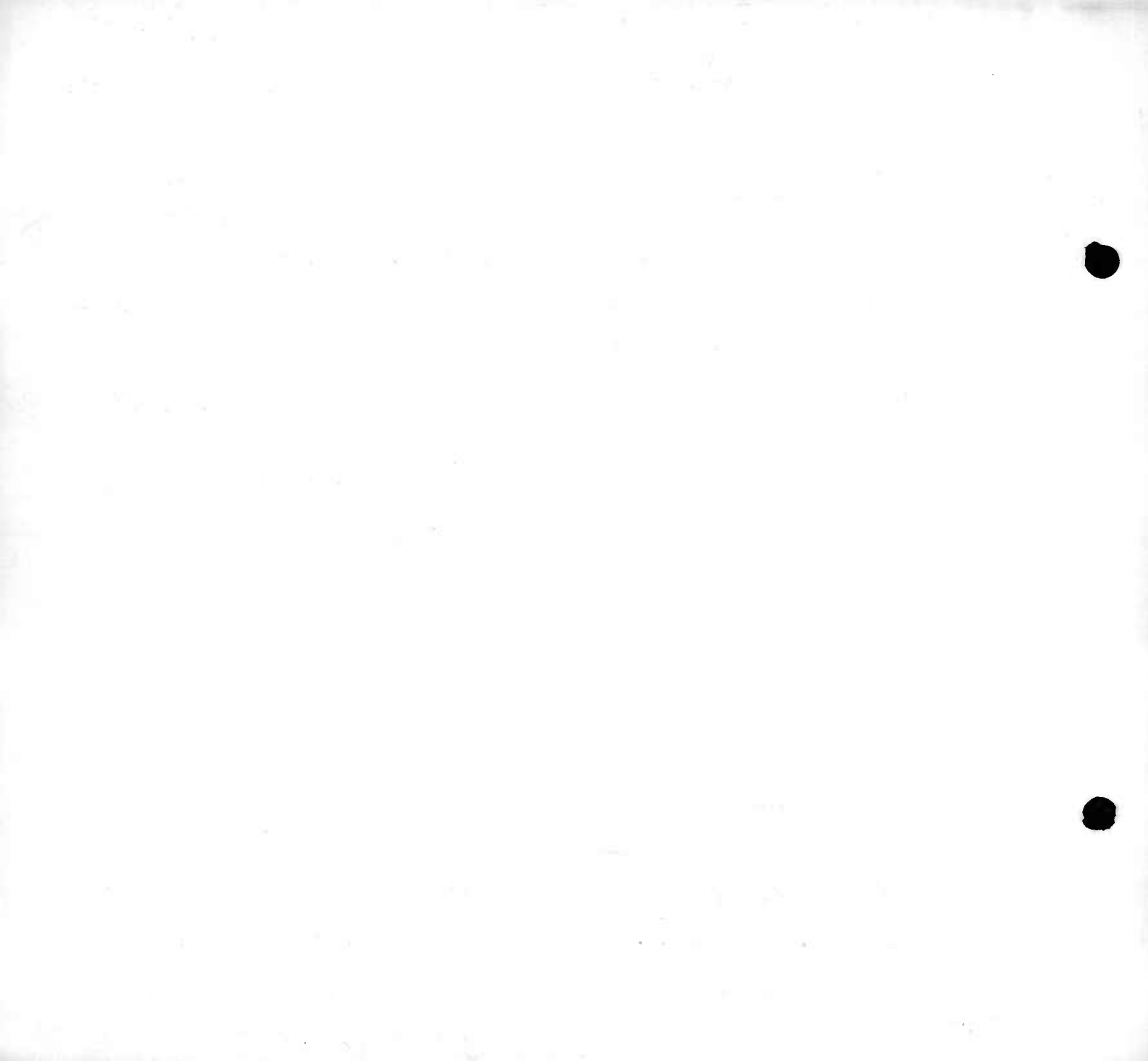
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

<div style="font-size: 2em; font-weight: bold;">C-640</div> <div style="font-size: 1.5em;">72 03799</div>		<div style="font-weight: bold;">BALTIMORE CITY HEALTH DEPARTMENT</div> <div style="font-weight: bold;">CERTIFICATE OF DEATH</div>		<div style="font-weight: bold;">REG. NO.</div> <div style="font-size: 1.5em;">72 03799</div>	
<div style="font-weight: bold;">BIRTH NO.</div> <div style="font-size: 1.5em;">1. NAME OF DECEASED (Type or Print)</div> <div style="font-size: 1.5em;">IRENE CARROLL</div>		<div style="font-weight: bold;">2. DATE AND HOUR OF DEATH</div> <div style="font-size: 1.5em;">4-13-72 11:30 P.M.</div>			
<div style="font-weight: bold;">3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</div> <div style="font-size: 1.5em;">FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)</div> <div style="font-size: 1.5em;">90 MT SINAI NURSING HOME 4612 PARK HEIGHT AVE BALTIMORE 21215</div>		<div style="font-weight: bold;">4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)</div> <div style="font-size: 1.5em;">A. STATE MD B. COUNTY 1601</div>			
<div style="font-weight: bold;">5. SEX</div> <div style="font-size: 1.5em;">F</div>		<div style="font-weight: bold;">6. RACE</div> <div style="font-size: 1.5em;">N</div>		<div style="font-weight: bold;">7. MARRIED</div> <div style="font-size: 1.5em;">NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/></div>	
<div style="font-weight: bold;">8. DATE OF BIRTH</div> <div style="font-size: 1.5em;">6-9-93</div>		<div style="font-weight: bold;">9. AGE (In years last birthday)</div> <div style="font-size: 1.5em;">78</div>		<div style="font-weight: bold;">10. CITIZEN OF WHAT COUNTRY?</div> <div style="font-size: 1.5em;">U.S.A.</div>	
<div style="font-weight: bold;">10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)</div> <div style="font-size: 1.5em;">HOUSE WIFE</div>		<div style="font-weight: bold;">10B. KIND OF BUSINESS OR INDUSTRY</div> <div style="font-size: 1.5em;">FREDERICKS MD</div>		<div style="font-weight: bold;">11. BIRTHPLACE (State or foreign country)</div> <div style="font-size: 1.5em;">FREDERICKS MD</div>	
<div style="font-weight: bold;">13. FATHER'S NAME</div> <div style="font-size: 1.5em;">CHARLIE HILL</div>		<div style="font-weight: bold;">14. MOTHER'S MAIDEN NAME</div> <div style="font-size: 1.5em;">SUSIE MILBERRY</div>		<div style="font-weight: bold;">17. INFORMANT</div> <div style="font-size: 1.5em;">MT. SINAI NURS. HOME</div>	
<div style="font-weight: bold;">15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)</div> <div style="font-size: 1.5em;">—</div>		<div style="font-weight: bold;">16. SOCIAL SECURITY NO.</div> <div style="font-size: 1.5em;">220-65-6594</div>		<div style="font-weight: bold;">ADDRESS</div> <div style="font-size: 1.5em;">Same as Above</div>	
<div style="font-weight: bold;">18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</div> <div style="font-size: 1.5em;">(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)</div> <div style="font-size: 1.5em;">412-3 I Antagonistic Heart Disease</div>		<div style="font-weight: bold;">CAUSE OF DEATH</div> <div style="font-size: 1.5em;">(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:</div> <div style="font-size: 1.5em;">Cirrhosis of liver</div>		<div style="font-weight: bold;">APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</div> <div style="font-size: 1.5em;">2 years</div>	
<div style="font-weight: bold;">ANTECEDENT CAUSES</div> <div style="font-size: 1.5em;">DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</div> <div style="font-size: 1.5em;">None</div>		<div style="font-weight: bold;">(B) DUE TO, OR AS A CONSEQUENCE OF:</div> <div style="font-size: 1.5em;">None</div>		<div style="font-weight: bold;">(C) DUE TO, OR AS A CONSEQUENCE OF:</div> <div style="font-size: 1.5em;">None</div>	
<div style="font-weight: bold;">OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).</div> <div style="font-size: 1.5em;">II</div>					
<div style="font-weight: bold;">19A. DATE OF OPERATION</div> <div style="font-size: 1.5em;">0</div>		<div style="font-weight: bold;">19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</div> <div style="font-size: 1.5em;">20A. AUTOPSY? (Yes or No)</div> <div style="font-size: 1.5em;">No</div>		<div style="font-weight: bold;">20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</div> <div style="font-size: 1.5em;">(If in Baltimore City, give exact location)</div>	
<div style="font-weight: bold;">21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</div> <div style="font-size: 1.5em;">(Notify medical examiner)</div>		<div style="font-weight: bold;">21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)</div> <div style="font-size: 1.5em;">21C. WHERE DID INJURY OCCUR?</div> <div style="font-size: 1.5em;">(If in Baltimore City, give exact location)</div>		<div style="font-weight: bold;">21F. HOW DID INJURY OCCUR?</div> <div style="font-size: 1.5em;">21E. INJURY OCCURRED</div> <div style="font-size: 1.5em;">While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/></div>	
<div style="font-weight: bold;">21D. TIME OF INJURY (APPROX.)</div> <div style="font-size: 1.5em;">(Month) (Day) (Year) (Hour)</div>		<div style="font-weight: bold;">22. I certify that (I) (this hospital) attended the deceased from</div> <div style="font-size: 1.5em;">Sept 22 1970 to April 13 1972</div> <div style="font-size: 1.5em;">that (I) lost saw the deceased alive on April 13 1972 and that in (my) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.</div>			
<div style="font-weight: bold;">23A. SIGNATURE</div> <div style="font-size: 1.5em;">Manuel Levin M.D.</div>		<div style="font-weight: bold;">23B. DATE SIGNED</div> <div style="font-size: 1.5em;">APR 20 1972</div>		<div style="font-weight: bold;">23C. PHYSICIAN'S NAME (Type)</div> <div style="font-size: 1.5em;">MANUEL LEVIN MD</div>	
<div style="font-weight: bold;">23D. ADDRESS</div> <div style="font-size: 1.5em;">6101 PARK HTS AVE. BALTO MD. 21215</div>		<div style="font-weight: bold;">24A. BURIAL CREMATION, REMOVAL (Specify)</div> <div style="font-size: 1.5em;">Burial</div>			
<div style="font-weight: bold;">24B. DATE</div> <div style="font-size: 1.5em;">4/28/72</div>		<div style="font-weight: bold;">24C. NAME OF CEMETERY OR CREMATORY</div> <div style="font-size: 1.5em;">Fairview Cemetery</div>		<div style="font-weight: bold;">24D. LOCATION (City, town, or county) (State)</div> <div style="font-size: 1.5em;">Frederick, Maryland</div>	
<div style="font-weight: bold;">25A. DATE REC'D BY HEALTH DEPT.</div> <div style="font-size: 1.5em;">APR 20 1972</div>		<div style="font-weight: bold;">25B. NAME OF REGISTRAR</div> <div style="font-size: 1.5em;">Robert E. Valley, M.D.</div>		<div style="font-weight: bold;">25C. FUNERAL DIRECTOR</div> <div style="font-size: 1.5em;">Kenneth H. Law, 4611 Park Heights Ave.</div>	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

C-462		72 03800		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 03800	
BIRTH NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) Gertrude Clarke				2. DATE AND HOUR OF DEATH April 18, 1972 11:30 A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY 703			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) HOUSE OF PINES 90 BELAIR RD.				C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX F 6. RACE N 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH 4-1-1915		9. AGE (in years last birthday) 57	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CLERK				10B. KIND OF BUSINESS OR INDUSTRY DRY CLEANERS		11. BIRTHPLACE (State or foreign country) MARYLAND	
13. FATHER'S NAME JAMES CLEARY				14. MOTHER'S MAIDEN NAME MARY HAGAN			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) No				16. SOCIAL SECURITY NO. 219327647		17. INFORMANT ADDRESS Mrs. Eileen Novotny - 5665 Ubrecht Rd.	
18. CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Acute Hepatic Coma		7 days	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) Chronic Nutritional Anorexia		years	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				Chronic Urinary Tract Infection Cachexia			
19A. DATE OF OPERATION				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 3/19/19 72 to 4/18/19 72 that (I) (we) last saw the deceased alive on 4/17/19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Albert B. Bradley				23B. DATE SIGNED 4/18/72		23C. PHYSICIAN'S NAME (Type) Albert B. Bradley, M.D.	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL				24B. DATE 4-21-72		24C. NAME of CEMETERY or CREMATORY HOLY REDEEMER Cem.	
25A. DATE REC'D BY HEALTH DEPT. APR 20 1972				25B. NAME OF REGISTRAR R. B. B. B.		25C. FUNERAL DIRECTOR Shirley Miller - 2334 Jefferson St.	
26A. DATE REC'D BY HEALTH DEPT.				26B. NAME OF REGISTRAR		26C. FUNERAL DIRECTOR	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 03801	
BIRTH NO. 72-0667672 03801				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <i>male Infant of Lmb Spearman</i>			2. DATE AND HOUR OF DEATH <i>4/14/72</i> <i>5 20</i> P. M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <i>31</i> <i>Baltimore City Hospitals</i> <i>4940 Eastern Avenue</i> <i>Baltimore, Maryland 21224</i>			4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <i>Maryland</i> 8. COUNTY <i>14031204</i> C. CITY OR TOWN <i>Baltimore</i> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <i>2915 W. Calhoun St</i>		
5. SEX <i>m</i>	6. RACE <i>B</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>7/14/72</i>	9. AGE (In years last birthday)	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. <i>34</i>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>md.</i>	
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS BCH RECORDS: 4940 Eastern Avenue 21224	
18. <i>778.7</i> I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) IMMEDIATE CAUSE <i>Asphyxia</i> DUE TO, OR AS A CONSEQUENCE OF: (B) <i>Cardiovascular Failure</i> DUE TO, OR AS A CONSEQUENCE OF: (C) <i>Asphyxia Prematurity</i> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>?</i> <i>?</i> <i>?</i>					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <i>Ass. Abortion - Placenta</i>					
19A. DATE OF OPERATION <i>None</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>Yes</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Initially medical examiner) <i>None</i>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <i>None</i>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <i>None</i>	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) <i>None</i>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <i>None</i>	
22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <i>4/14/72</i> 19 <i>72</i> to <i>4/14/72</i> 19 <i>72</i> that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <i>April 14</i> 19 <i>72</i> and that <input checked="" type="checkbox"/> (my) (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>W. M. Crane</i>				23B. DATE SIGNED <i>4/14/72</i>	
23C. PHYSICIAN'S NAME (Type) <i>Wm M Crane</i>				23D. ADDRESS <i>Baltimore City Hospital</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Cremated</i>		24B. DATE <i>4/17/72</i>		24C. NAME OF CEMETERY or CREMATORY <i>Baltimore City Hospitals</i>	
24D. LOCATION (City, town, or county) <i>21224</i>		24E. LOCATION (State) <i>Baltimore, Md.</i>			
25A. DATE REC'D BY HEALTH DEPT. <i>APR 20 1972</i>		25B. NAME OF REGISTRAR <i>Phyllis J. ...</i>		25C. FUNERAL HOME ADDRESS <i>37 ...</i>	

Address 2015 McCullah St. (No such address as 2915
Birth Cert correct as above McCullah)

FUNERAL DIRECTOR: IMPORTANT

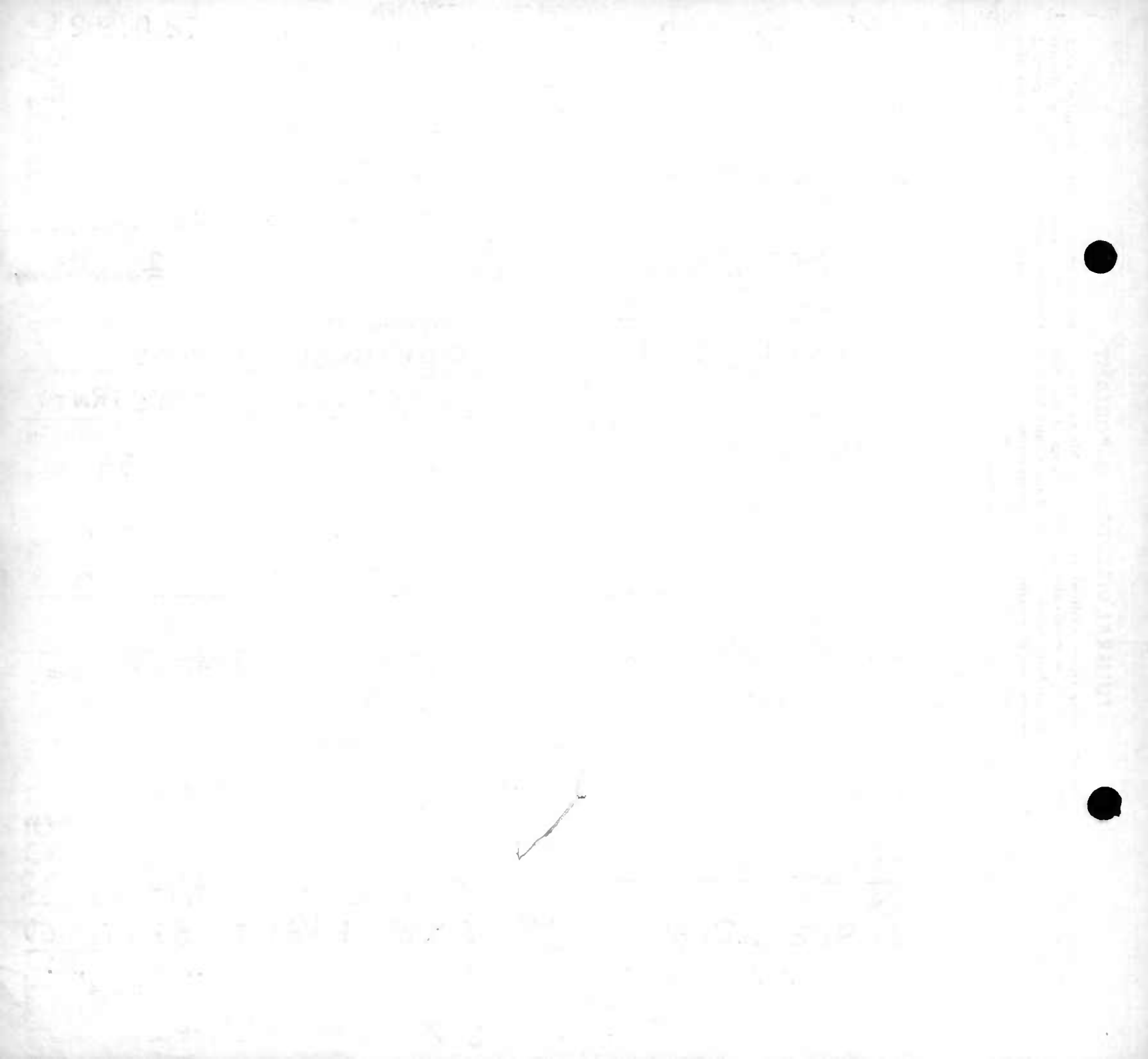
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

REG. NO. 72 03802

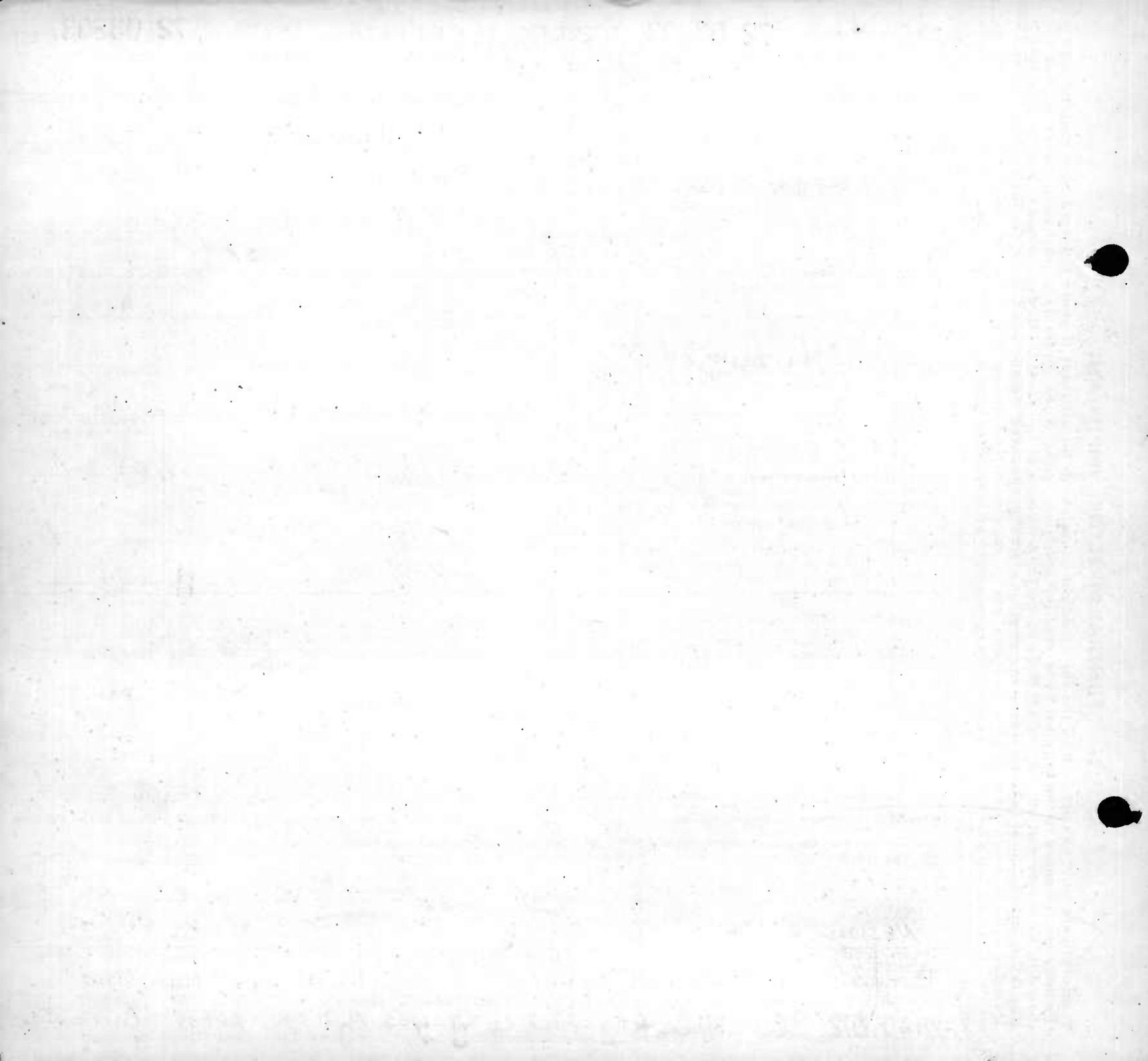
BIRTH NO. 72-059422 03802		1. NAME OF DECEASED (Type or Print) BABY GIRL DIGGS Gertrude		2. DATE AND HOUR OF DEATH 4/14/72 7 16 M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) BALTIMORE CITY HOSPITALS 4940 Eastern Avenue Baltimore, Maryland 21224			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY 908 C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 2219 Aisquith Street 21218		
5. SEX Female	6. RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/12/72	9. AGE (In years lost birthday) 2	If Under 1 Yr. Months: 2 Days: 2 Hours: 2 Min. 2
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
13. FATHER'S NAME SAMUEL ESTERS			14. MOTHER'S MAIDEN NAME GERTRUDE DIGGS		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS Dr J. SRABSTEIN 5938 E. PRATT	
18. 77201 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) HYPOXIA (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: PERSISTENT APNEAS (B) DUE TO, OR AS A CONSEQUENCE OF: BRAIN DAMAGE (C) DUE TO, OR AS A CONSEQUENCE OF: ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 54 48h 48h		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED White At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 4/12/72 to 4/14/72 that (I) (we) last saw the deceased alive on 4/14/72 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Jorge Srabstein				23B. DATE SIGNED 4/14/72	
23C. PHYSICIAN'S NAME (Type) JORGE SRABSTEIN MD		23D. ADDRESS 5938 E. PRATT BALTIMORE			
24A. BURIAL CREMATION, REMOVAL (Specify) Cremated		24B. DATE 4/17/72		24C. NAME OF CEMETERY OR CREMATORY Baltimore City Hospitals	
24D. LOCATION (City, town, or county) (State) 4940 Eastern Ave., Baltimore, Md.		24E. DATE REC'D BY HEALTH DEPT. APR 20 1972			
24F. NAME OF REGISTRAR Robert E. Pratt		25C. FUNERAL DIRECTOR ADDRESS 21224			
HOSPITAL DISPOSAL					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

G-320 72 03803 BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 72 03803	
BIRTH NO. _____ 1. NAME OF DECEASED (Type or Print) ANNIE BELL GATES (OR) ANNABELLE GATES		2. DATE AND HOUR OF DEATH APRIL 15, 1972 6:05 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) SOUTH BALTIMORE GENERAL HOSPITAL 43		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY 21229 C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 504 N. Loudon Ave.	
5. SEX Female	6. RACE BLACK	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-4-20
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) _____		10B. KIND OF BUSINESS OR INDUSTRY _____	9. AGE (In years last birthday) 51 If Under 1 Yr. Months: _____ Days: _____ If Under 24 Hrs. Hours: _____ Min. _____
11. BIRTHPLACE (State or foreign country) South Carolina		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME David Manning		14. MOTHER'S MAIDEN NAME Annie Alston	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 217-07-5353	
17. INFORMANT Rosalee Hammond ADDRESS 504 N. Loudon Ave. (sister)		18. 250.9 I CAUSE OF DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE SEVERE DEHYDRATION DUE TO, OR AS A CONSEQUENCE OF: MALNUTRITION (B) DIABETES MELLITUS DUE TO, OR AS A CONSEQUENCE OF: _____ (C) CVA	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		PNEUMONIA	
19A. DATE OF OPERATION _____		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED _____	
20A. AUTOPSY? (Yes or No) _____		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? _____	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) _____		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) _____	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? _____	
22. I certify that (I) (this hospital) attended the deceased from 4-11 19 72 to 4-15 19 72 , that (I) (we) last saw the deceased alive on 4-15 19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE Nelson R. de Lara DEGREE _____		23B. DATE SIGNED April 15, 1972	
23C. PHYSICIAN'S NAME (Type) NELSON R. DE LARA DEGREE _____		23D. ADDRESS SOUTH BALT. GEN. HOSPITAL	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4-19-72	
24C. NAME OF CEMETERY or CREMATORY Mt. Auburn		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. APR 20 1972		25B. NAME OF REGISTRAR Robert E. Taylor, Jr.	
25C. FUNERAL DIRECTOR Charles A. Rice ADDRESS 661 W. Barre St.		25D. _____	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

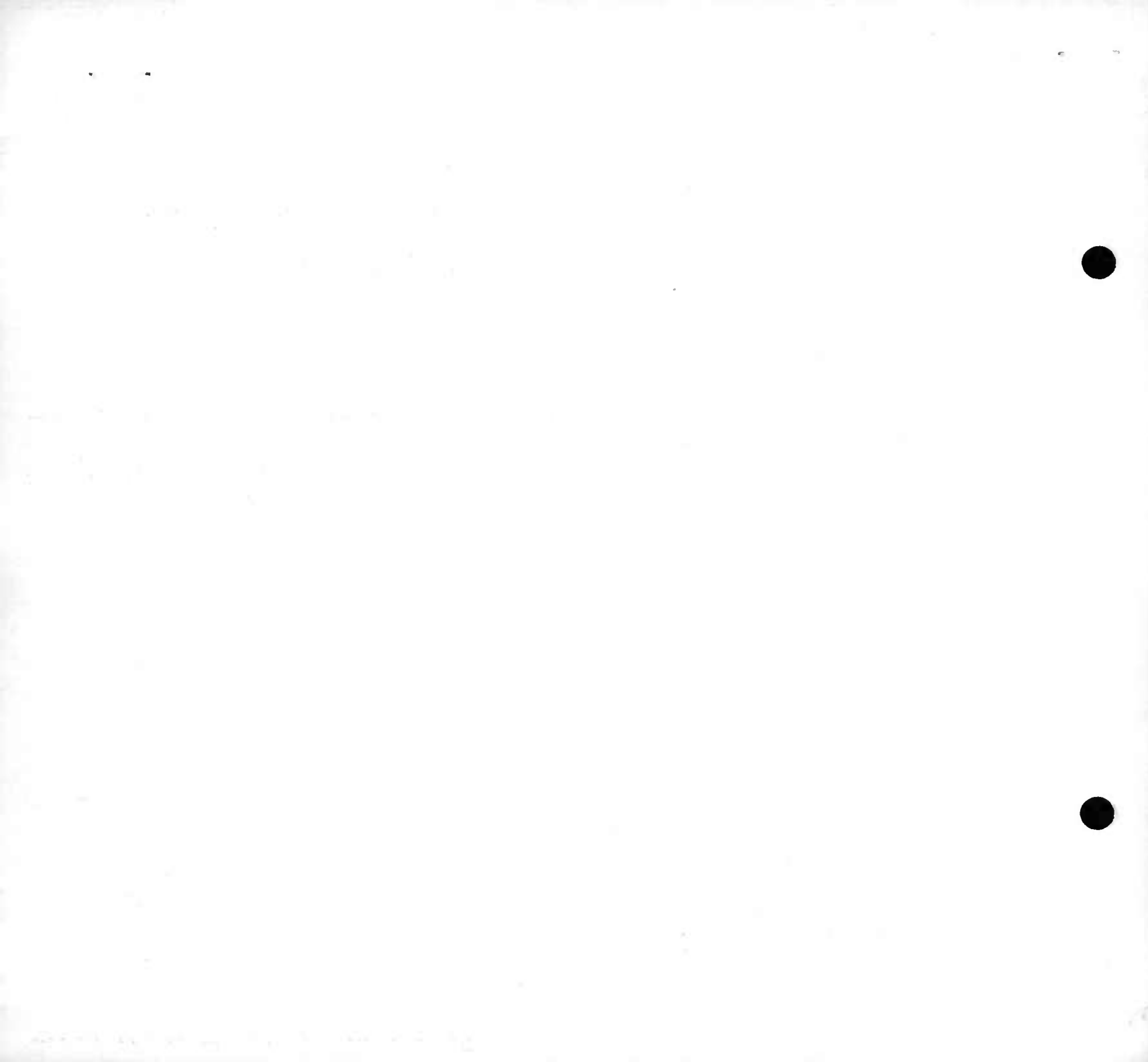
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>72 03804</u>	
<p>BIRTH NO. 1. NAME OF DECEASED (Type or Print) <u>Caroline A. Knight</u></p>		<p>2. DATE AND HOUR OF DEATH <u>4-13-72</u> <u>1:50 P. M.</u></p>			
<p>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>Bolton Hill Nursing Home</u></p>		<p>4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) A. STATE <u>MD.</u> B. COUNTY <u>806</u> C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>1817 Dallas Street</u></p>			
<p>5. SEX <u>7</u></p>	<p>6. RACE <u>W</u></p>	<p>7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/></p>		<p>8. DATE OF BIRTH <u>10-10-88</u></p>	<p>9. AGE (In years last birthday) <u>83</u></p>
<p>10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)</p>		<p>10B. KIND OF BUSINESS OR INDUSTRY</p>		<p>11. BIRTHPLACE (State or foreign country)</p>	
<p>12. CITIZEN OF WHAT COUNTRY?</p>		<p>13. FATHER'S NAME</p>			
<p>14. MOTHER'S MAIDEN NAME</p>		<p>15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)</p>			
<p>16. SOCIAL SECURITY NO. <u>217-03-0425</u></p>		<p>17. INFORMANT <u>Mrs. Suttie Boone</u> <u>1813 N. Dallas St.</u> <u>Medical Records</u></p>			
<p>18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p>		<p>CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>Cerebral Left Stroke</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>diabetes mellitus</u> DUE TO, OR AS A CONSEQUENCE OF: (C) <u>arteriosclerosis</u></p>		<p>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>yes</u> <u>yes</u> <u>yes</u></p>	
<p>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).</p>					
<p>19A. DATE OF OPERATION <u>0</u></p>		<p>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</p>		<p>20A. AUTOPSY? (Yes or No)</p>	
<p>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</p>		<p>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/></p>			
<p>21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)</p>		<p>21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)</p>			
<p>21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)</p>		<p>21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/></p>		<p>21F. HOW DID INJURY OCCUR?</p>	
<p>22. I certify that (I) (this hospital) attended the deceased from <u>1/29</u> 19<u>69</u> to <u>4/15</u> 19<u>72</u> that (I) (we) last saw the deceased alive on <u>4/15</u> 19<u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</p>					
<p>23A. SIGNATURE <u>[Signature]</u></p>		<p>23B. DATE SIGNED <u>4/12/72</u></p>		<p>23C. PHYSICIAN'S NAME (Type) <u>ARLAN H. MARCH</u></p>	
<p>23D. ADDRESS <u>212 Red St Balt MD</u></p>		<p>24A. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u></p>			
<p>24B. DATE <u>4/20/72</u></p>		<p>24C. NAME OF CEMETERY OR CREMATORY <u>Louden Park Cemetery</u></p>		<p>24D. LOCATION (City, town, or county) (State) <u>Balt. Md.</u></p>	
<p>25A. DATE REC'D BY HEALTH DEPT. <u>APR 20 1972</u></p>		<p>25B. NAME OF REGISTRAR <u>Robert E. Jones, Jr.</u></p>		<p>25C. FUNERAL DIRECTOR <u>Wm F. March</u></p>	
<p>ADDRESS <u>928 E. North Ave</u></p>					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

M-635		72 03805		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 03805	
BIRTH NO.				1. NAME OF DECEASED (Type or Print) MARTIN, JOHN			
2. DATE AND HOUR OF DEATH 4/16/72 11:50 P.M.				3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION SINAI HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			
4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MD. B. COUNTY BALTO				C. CITY OR TOWN BALTO D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
E. STREET AND NUMBER 1643 NORMAL AVE #13				5. SEX MALE 6. RACE NEGRO			
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH 11/14/13 9. AGE (in years last birthday) 58				10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			
11. BIRTHPLACE (State or foreign country) N.C.				12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME Percy Martin				14. MOTHER'S MAIDEN NAME Elizabeth Black			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. 219-05-9707			
17. INFORMANT MRS LUCINDA MARTIN				ADDRESS 1643 Normal Ave			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) HEPATO RENAL SYNDROME				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 DAYS			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) DUE TO, OR AS A CONSEQUENCE OF:			
(C) DUE TO, OR AS A CONSEQUENCE OF:							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 4/16/72 to 4/16/72 19 72 and that (I) (we) last saw the deceased alive on 4/16/72 19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE DAVID CLASED, M.D.				23B. DATE SIGNED 4/16/72		23C. PHYSICIAN'S NAME (Type)	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial		4-20-72		Balto. Cemetery		Balto Md.	
25A. DATE REC'D BY HEALTH DEPT. APR 20 1972		25B. NAME OF REGISTRAR Robert E. Galt		25C. FUNERAL DIRECTOR WMC MARCH		ADDRESS 928 E. North Ave	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>72 03806</u>	
BIRTH NO. <u>W-252</u>		72 03806		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <u>ELSIE T WASHINGTON</u>			2. DATE AND HOUR OF DEATH <u>APRIL 18 72</u> <u>2:20 A. M.</u>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <u>44</u> (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>UNION MEMORIAL HOSPITAL</u>			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>907</u>		
			C. CITY OR TOWN <u>BALTIMORE</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER <u>1655 CARSWELL ST.</u>		
5. SEX <u>F</u>	6. RACE <u>B</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>04-18-10</u>	9. AGE (in years last birthday) <u>61</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>S. CAROLINA</u>	
13. FATHER'S NAME <u>McKell Taylor</u>			12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Charles Washington 1655 Carswell St.</u>	
18. <u>582X I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>CHRONIC RESPIRATORY ARREST</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>UREMIA</u> DUE TO, OR AS A CONSEQUENCE OF: (C) <u>CHRONIC RENAL FAILURE</u>		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>YES</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>04/06</u> 19 <u>72</u> to <u>04/18</u> 19 <u>72</u> that (I) (we) last saw the deceased alive on <u>04/18</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Cesar Villanar</u>			23B. DATE SIGNED <u>4/18/72</u>		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>
23C. PHYSICIAN'S NAME (Type) <u>CESAR VILLANAR</u>			23D. ADDRESS <u>3314 and Calvert St.</u>		
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>	24B. DATE <u>4-20-72</u>	24C. NAME of CEMETERY or CREMATORY <u>MT CALVARY CEM.</u>		24D. LOCATION (City, town, or county) (State) <u>Anne Arundel Cty., Md</u>	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR <u>9720</u>		25C. FUNERAL DIRECTOR <u>WMPC</u>	
				ADDRESS <u>928 E North Ave</u>	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

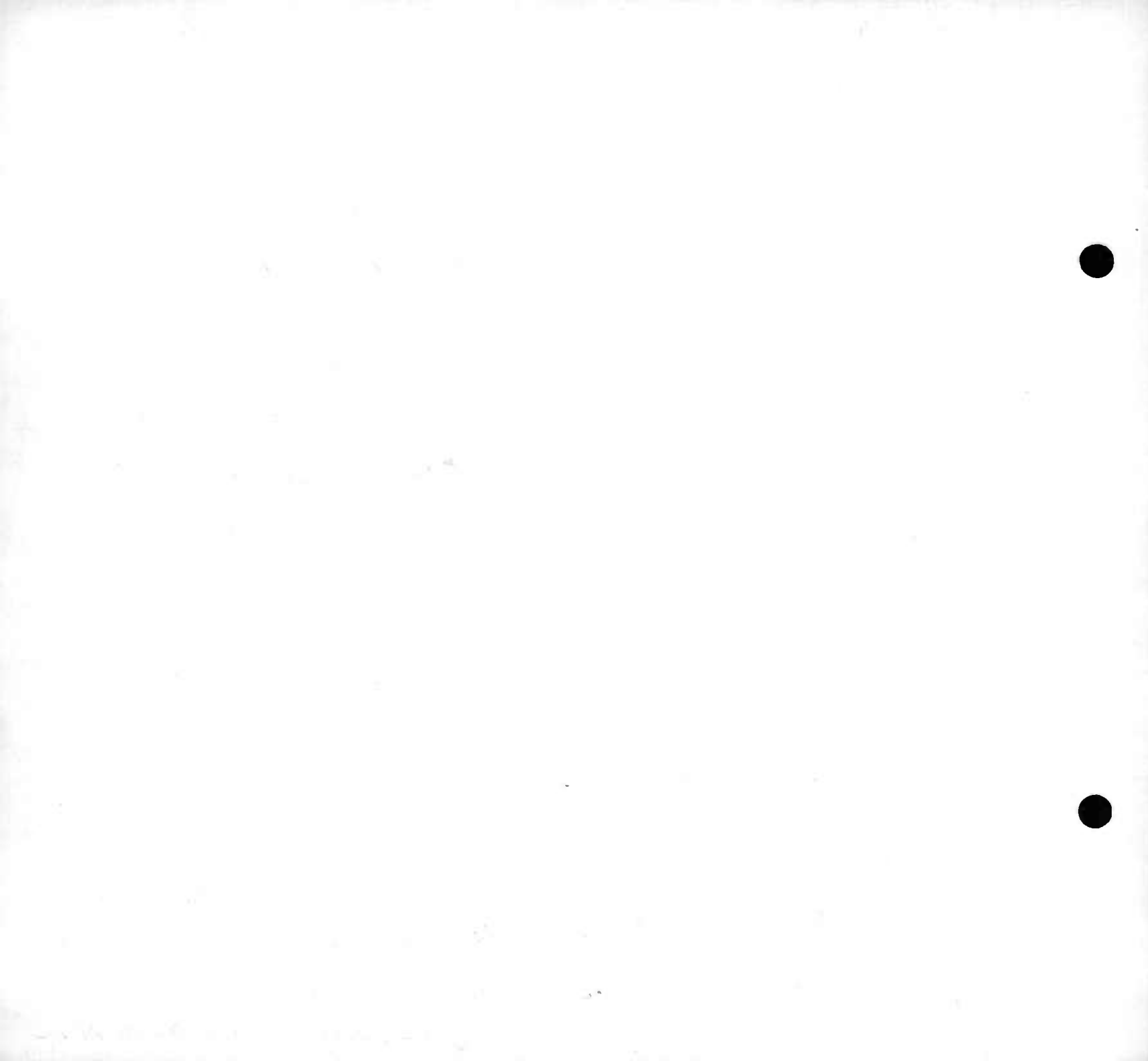
BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. <u>72 03807</u>
1. NAME OF DECEASED (Type or Print) <u>Anna E. Thornton</u>		2. DATE AND HOUR OF DEATH <u>April 15 1972 2:30 p.m.</u>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>Sinai Hosp. of Balt.</u>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MD.</u> B. COUNTY <u>Balt City</u> C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>5516 Gist Ave.</u>		
5. SEX <u>F</u>	6. RACE <u>Bl.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5-15-83</u>	9. AGE (In years lost birthday) <u>88</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>VA</u>
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME <u>Mitchell</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <u>Virginia Holt 5516 Gist Ave</u>
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Chronic Renal Failure</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Unknown</u>		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) _____ DUE TO, OR AS A CONSEQUENCE OF: (C) _____		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		<u>Subarachnoid Hemorrhage</u>		
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from <u>4-3-72</u> to <u>4-15-72</u> that (I) (we) last saw the deceased alive on <u>4-15-72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <u>Joshua Frankel M.D.</u>		23B. DATE SIGNED <u>4-15-72</u>		23C. PHYSICIAN'S NAME (Type) <u>Joshua Frankel M.D.</u>
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>4-21-72</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Martinsville Va.</u>
25A. DATE REC'D BY HEALTH DEPT. <u>APR 20 1972</u>		25B. NAME OF REGISTRAR <u>Wm C March</u>		25C. FUNERAL DIRECTOR ADDRESS <u>928 E North Ave</u>



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

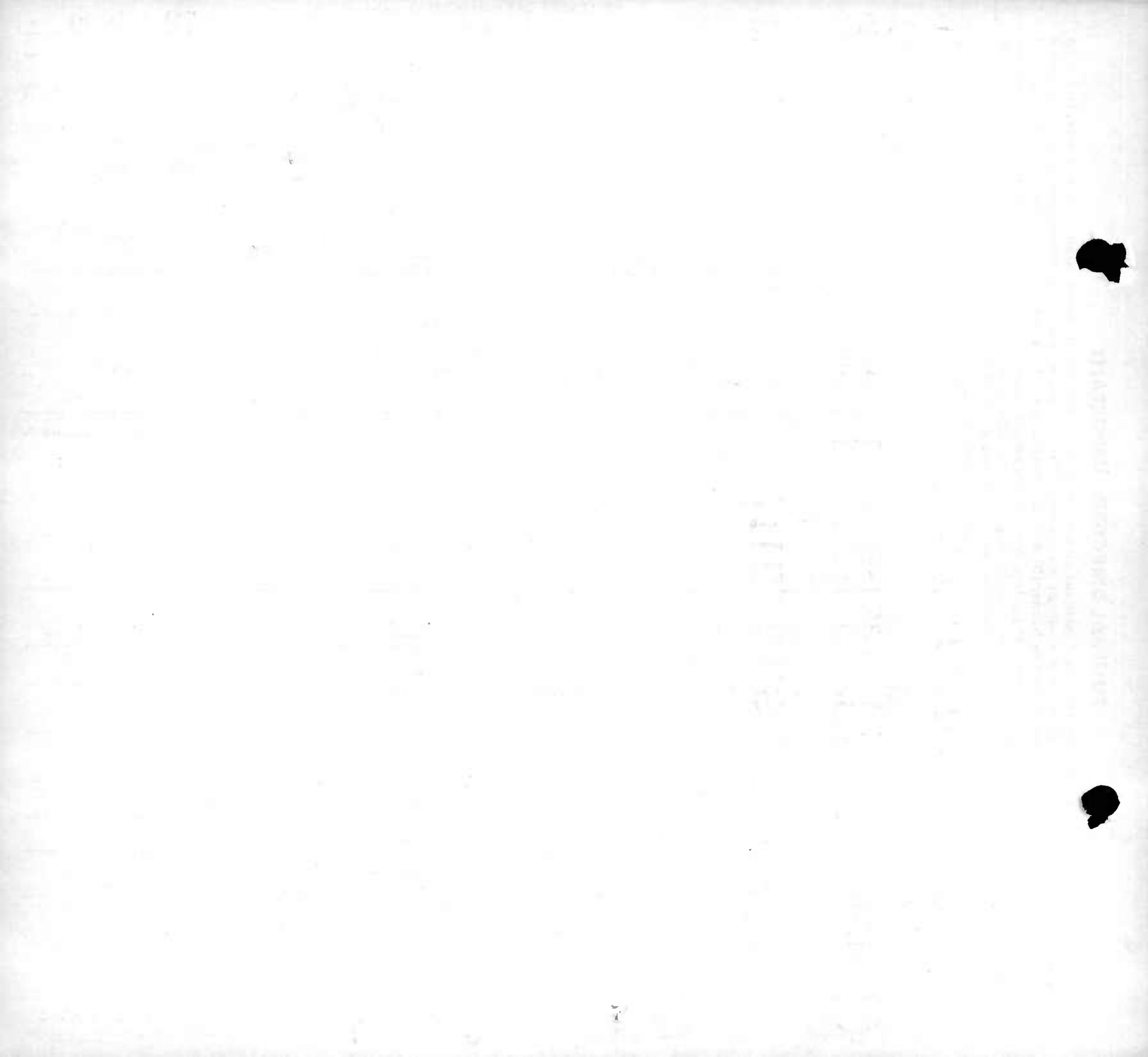
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>72 03808</u>	
P-320 72 03808				CERTIFICATE OF DEATH	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>Pettus, Philip E. Jr</u>		2. DATE AND HOUR OF DEATH <u>4-17-72</u> <u>10:40</u> <u>1:14 PM</u>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>907</u>		C. CITY OR TOWN <u>Baltimore</u>	
FULL NAME OF HOSPITAL OR INSTITUTION <u>Mt. Sinai Nursing Home</u> <u>4413 Park Heights Ave.</u>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <u>M</u>	6. RACE <u>C</u>	7. MARRIED <input type="checkbox"/> NEVER-MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-12-14</u> <u>57</u>	9. AGE (In years last birthday)	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Richmond Va.</u>	
13. FATHER'S NAME <u>Phillip E. Pettus</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Mitchell</u>		12. CITIZEN OF WHAT COUNTRY?	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Emma Beasley 2639 Aisguith St.</u>	
18. <u>433.9 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc., it means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>Cerebrovascular Acc.</u> DUE TO, OR AS A CONSEQUENCE OF: <u>R Sided Pontine Infarct</u> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>6 mo</u>	
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>NO</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>3/20</u> 19 <u>72</u> to <u>4/17</u> 19 <u>72</u> that (I) (we) last saw the deceased alive on <u>4/16</u> 19 <u>72</u> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>E. S. Hallins MD</u> DEGREE				23B. DATE/SIGNED <u>4/19/72</u>	
23C. PHYSICIAN'S NAME (Type) <u>E. S. HALLINS MD</u> DEGREE				23D. ADDRESS <u>6000 PARKHILLS AVE BALTIMORE MD 21205</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>4/21/72</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Mt. Auburn Cem</u>	
24D. LOCATION (City, town, or county) (State) <u>Balts Md.</u>		25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR	
25C. FUNERAL DIRECTOR <u>WMC MARCH</u>		25D. ADDRESS <u>928 E North Ave</u>		25E. DATE REC'D BY HEALTH DEPT.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

<div style="display: flex; justify-content: space-between;"> 7-236 72 03809 BALTIMORE CITY HEALTH DEPARTMENT </div> <h2 style="text-align: center;">CERTIFICATE OF DEATH</h2>		REG. NO. 72 03809	
BIRTH NO. 7-236		1. NAME OF DECEASED (Type or Print) <u>Zoster Laura Morris</u>	
2. DATE AND HOUR OF DEATH <u>April 18, 1972</u> <u>5⁰⁷</u> <u>A.M.</u>		3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>The Johns Hopkins Hospital</u>	
4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>806</u>		C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER <u>1763 E. North Avenue</u>		5. SEX <u>Female</u> 6. RACE <u>Black</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	
8. DATE OF BIRTH <u>11/12/16</u> 9. AGE (in years last birthday) <u>55</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>S.C.</u>	
11. BIRTHPLACE (State or foreign country) <u>S.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>WALTER BROWN</u>		14. MOTHER'S MAIDEN NAME <u>CLARA JACKSON</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>Willie Jackson 2913 The Alameda</u>	
17. INFORMANT ADDRESS <u>Willie Jackson 2913 The Alameda</u>		18. CAUSE OF DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Cerebrovascular Accident</u> (B) <u>ASCD</u> (C) <u>Hypertension</u>	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>Many yr</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>10 days</u>	
19A. DATE OF OPERATION <u>4/12/72</u> 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>NO</u>		20A. AUTOPSY? (Yes or No) <u>NO</u> 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>Many yr</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>NO</u>	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <u>NO</u>		21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) <u>4/12/72</u>	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <u>NO</u>	
22. I certify that (1) (this hospital) attended the deceased from <u>4/12</u> 19 <u>72</u> to <u>4/18</u> 19 <u>72</u> that (1) (we) last saw the deceased alive on <u>4/18</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the cause stated above. (1) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <u>W. Rohde MD</u> DEGREE <u>MD.</u>		23B. DATE SIGNED <u>4/18/72</u>	
23C. PHYSICIAN'S NAME (Type) <u>William Rohde</u>		23D. ADDRESS <u>604 North Broadway Baltimore</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>4/22/72</u>	
24C. NAME of CEMETERY or CREMATORY <u>Arbutus Mem. Park</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore Md.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>APR 20 1972</u>		25B. NAME OF REGISTRAR <u>Wm S March</u>	
25C. FUNERAL DIRECTOR ADDRESS <u>928 E. North Ave</u>		25D. <u>March</u>	



60-95-23 djr

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

REG. NO. 72 03810

A523 BIRTH NO. 72 03810		BALTIMORE CITY HEALTH DEPARTMENT	
1. NAME OF DECEASED (Type or Print) Richard Anstatt		2. DATE AND HOUR OF DEATH April 16, 1972 2:20 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE Maryland B. COUNTY Baltimore	
FULL NAME OF HOSPITAL OR INSTITUTION Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland 21224		C. CITY OR TOWN D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER Box 304 Route 10 21219			
5. SEX Male	6. RACE Caucasian	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7/28/05
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mech.		10B. KIND OF BUSINESS OR INDUSTRY Land Systems	9. AGE (In years last birthday) 66
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Erhard Leppert		14. MOTHER'S MAIDEN NAME Julia	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service		16. SOCIAL SECURITY NO.	17. INFORMANT 4940 Eastern Avenue BCH: RECORDS Baltimore, Maryland 21224
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) LACTIC Acidosis		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: phenformin Rx (B) DUE TO, OR AS A CONSEQUENCE OF: DIABETES mellitus (C) ? Pulmonary embolus	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			
19A. DATE OF OPERATION 0	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY (Yes or No) NO	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? NO
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 4/16/1972 to 4/16/1972 that (I) (we) last saw the deceased alive on 4/16/1972 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE Ronald Innerfield M.D.		23B. DATE SIGNED 4/16/72	
23C. PHYSICIAN'S NAME (Type) Ronald Innerfield M.D.		23D. ADDRESS 6004 Eastern Avenue 21224	
24A. BURIAL CREMATION REMOVAL (Specify) Burial	24B. DATE 4/21/72	24C. NAME OF CEMETERY OR CREMATORY Grove Church Cem.	24D. LOCATION (City, town, or county) (State) North Bergen, Hudson Co, New Jersey
25A. DATE REC'D BY HEALTH DEPT. APR 20 1972	25B. NAME OF REGISTRAR Robert E. Fisher, M.D.	25C. FUNERAL DIRECTOR Schwartz, Inc. 2101 Frederick Ave. Balt. Md.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 03811	
BIRTH NO. 72 03811		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) Essie Thompson		2. DATE AND HOUR OF DEATH 4-18-72 12-50 P. M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Lutheran Hospital of Maryland		A. STATE Maryland		B. COUNTY 1605	
		C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER 852 Whitmore Avenue			
5. SEX Female	6. RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-16-04	9. AGE (in years last birthday) 67	10. Under 1 Yr. Months: Days: 11. Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		11. BIRTHPLACE (State or foreign country) Georgia		12. CITIZEN OF WHAT COUNTRY USA	
13. FATHER'S NAME Willie Montgomery		14. MOTHER'S MAIDEN NAME Mary M. Riley			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS Ulysess Thompson - 3813 - Baker St.	
18. 250.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: CARDIO-PULMONARY ARREST			
		(B) ASCVD, CHF, PLEURAL EFFUSION DUE TO, OR AS A CONSEQUENCE OF:			
		(C) DIABETES MELLITUS			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that the (this hospital) attended the deceased from 3/12/1972 to 4/18/1972 that it (we) lost saw the deceased alive on 4/18/1972 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. It (We) (did) did not view the body after death.					
23A. SIGNATURE [Signature]		23B. DATE SIGNED		23C. PHYSICIAN'S NAME (Type) SEIN LWIN	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE 4-22-72		24C. NAME OF CEMETERY OR CREMATORY Arboretus Mem'lk.	
24D. LOCATION (City, town, or county) (State) Balto, Md		25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR Robert E. Barber, Jr.	
25C. FUNERAL DIRECTOR		25D. ADDRESS [Signature] 1100 - Lawrence St.			

Don't
forget to

Don't forget to

Don't forget to

R 262

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Albert Rogers		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour 4 18 72 1:20 A.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 34 Bon Secours Hospital		3. DATE PRONOUNCED DEAD Month Day Year Hour 4 18 72 1:20 A.	
5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 1602			
6. SEX Male	7. RACE Negro	B. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH 12-5-17		10. AGE (In years lost birthday) 54	
11. BIRTHPLACE (State or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		14B. KIND OF BUSINESS OR INDUSTRY B & O R. R.	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO.	
18. INFORMANT Mrs. Josie Rogers		ADDRESS 1531 Edmondson Avenue	
19. 410.9		CAUSE OF DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE Acute coronary artery thrombosis DUE TO, OR AS A CONSEQUENCE OF:	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(B) DUE TO, OR AS A CONSEQUENCE OF:	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		(C) DUE TO, OR AS A CONSEQUENCE OF:	
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		22F. HOW DID INJURY OCCUR?	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Werner U. Spitz, M.D.		Deputy CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4-22-72	
24C. NAME OF CEMETERY or CREMATORY Arbutus Memorial Pk.		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. APR 20 1972		25B. NAME OF REGISTRAR Robert E. Fairley, M.D.	
25C. FUNERAL DIRECTOR Morton & Dyett Funeral Home-1701 Laurens St.		ADDRESS	

ST-10-51

ST-10-51

John R. R.

North Carolina

John R. R.

John R. R.

John R. R.

John R. R.

WALLACE BOULE

25/4/74

John R. R.

John R. R.

John R. R.

John R. R.

John R. R.

John R. R.

John R. R.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

72 03813		BALTIMORE CITY HEALTH DEPARTMENT		72 03813	
BIRTH NO.		CERTIFICATE OF DEATH		REG. NO.	
1. NAME OF DECEASED (Type or Print) <u>DAY TEMPERANCE</u>		2. DATE AND HOUR OF DEATH <u>4-17-72</u> <u>8:45 p.</u> M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>MD</u> B. COUNTY <u>1303</u>			
FULL NAME OF HOSPITAL OR INSTITUTION <u>39</u> <u>Provident Hospital Complex</u>		C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		E. STREET AND NUMBER <u>2536 Madison Ave.</u>			
5. SEX <u>F.</u>	6. RACE <u>Black</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-01-1900</u>	9. AGE (in years last birthday) <u>72</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even, if retired)		10B. KIND OF BUSINESS OR INDUSTRY <u>Domestic</u>		11. BIRTHPLACE (State or foreign country) <u>Lotham, Md.</u>	
13. FATHER'S NAME <u>John Harris</u>		14. MOTHER'S MAIDEN NAME <u>Temple Harris</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>29-32-0989</u>		17. INFORMANT <u>Joseph Dial - 3904 - Cedar Lake</u>	
18. <u>486X I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>II</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		(A) IMMEDIATE CAUSE <u>Pneumonia</u> DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u>	
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from _____ 19 _____ to _____ 19 _____ that (I) (we) last saw the deceased alive on _____ 19 _____ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Dr. G. Kington</u>		23B. DATE SIGNED		23C. PHYSICIAN'S NAME (Type) <u>Dr. G. Kington</u>	
23D. ADDRESS		23E. DEGREE			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <u>4-21-72</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Mt. Auburn Cem.</u>	
24D. LOCATION (City, town, or county) (State) <u>Disto, Md.</u>		25A. DATE REC'D BY HEALTH DEPT. <u>APR 20 1972</u>			
25B. NAME OF REGISTRAR <u>Robert E. Farber, R.D.</u>		25C. FUNERAL DIRECTOR <u>Joseph Dial</u>		25D. ADDRESS <u>F.H. 1401 - Harvers</u>	

12.2.4 12.2.4 12.2.4
12.2.4 12.2.4 12.2.4
12.2.4 12.2.4 12.2.4

12.2.4 12.2.4 12.2.4
12.2.4 12.2.4 12.2.4
12.2.4 12.2.4 12.2.4

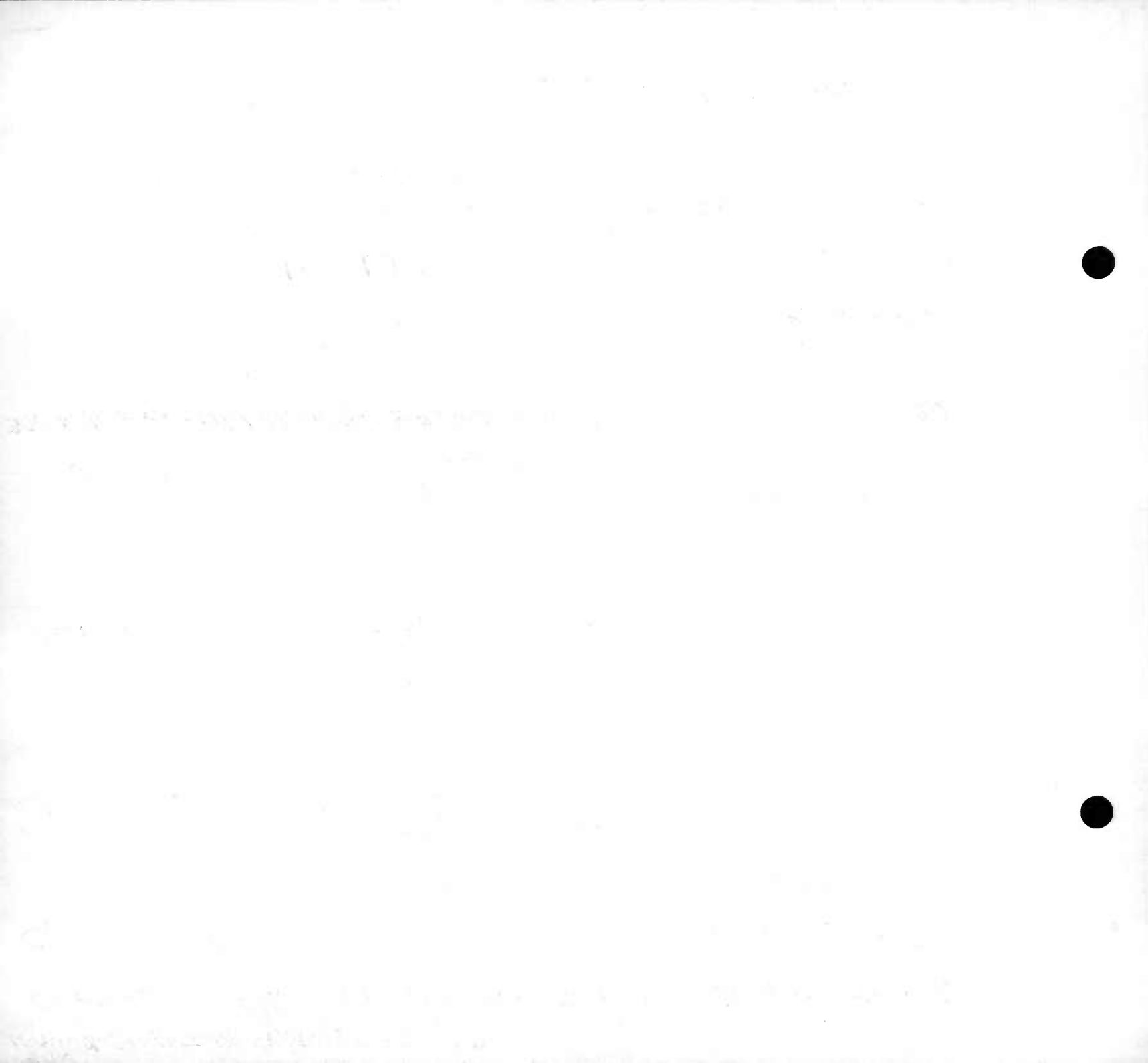
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
72 03814					X REG. NO. 72 03814				
BIRTH NO.					1. NAME OF DECEASED (Type or Print) COX, GORDON Ellsworth				
2. DATE AND HOUR OF DEATH 4/17/72 9:15 A.M.									
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD					4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)				
FULL NAME OF HOSPITAL OR INSTITUTION MARYLAND GENERAL HOSPITAL 48					A. STATE MD.				
IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION					B. COUNTY 6 CALVERT 5400				
5. SEX m					6. RACE w				
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>					8. DATE OF BIRTH 9/4/05				
9. AGE (in years last birthday) 66					10. UNDER 1 Yr. Months Days 11. UNDER 24 Hrs. Hours Min.				
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED					10B. KIND OF BUSINESS OR INDUSTRY Postmaster-Retired				
11. BIRTHPLACE (State or foreign country) MARYLAND					12. CITIZEN OF WHAT COUNTRY? U.S.				
13. FATHER'S NAME James Thomas Cox					14. MOTHER'S MAIDEN NAME Sadie Sarah Wilkerson				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No					16. SOCIAL SECURITY NO. 216- 5-817				
17. INFORMANT Mrs Eva Cox					ADDRESS Sunderland, Md.				
18. 199.0 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Cardiorespiratory arrest (B) Metastatic Carcinoma - diffuse (C)				
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).									
19A. DATE OF OPERATION 18 Feb 72					19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Exploratory Laparotomy				
20A. AUTOPSY? (Yes or No) No					20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input checked="" type="checkbox"/>					21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)									
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)					21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				
21F. HOW DID INJURY OCCUR?									
22. I certify that (if) (this hospital) attended the deceased from Feb 13 1972 to 17 Apr 1972 that (if) (we) last saw the deceased alive on 17 Apr 1972 and that (in) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (if) (We) (did) (did not) view the body after death.									
23A. SIGNATURE [Signature]					23B. DATE SIGNED 17 Apr 72				
23C. PHYSICIAN'S NAME (Type) [Signature]					23D. ADDRESS [Signature]				
24A. BURIAL CREMATION, REMOVAL (Specify) Burial					24B. DATE 4/20/72				
24C. NAME of CEMETERY or CREMATORY Mt Harmony Church Cemetery					24D. LOCATION (City, town, or county) (State) Owings, Calvert Md.				
25A. DATE REC'D BY HEALTH DEPT. APR 20 1972					25B. NAME OF REGISTRAR Robert E. Taylor				
25C. FUNERAL DIRECTOR Buchanan Funeral Home					ADDRESS Owings, Md.				



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 03815	
72 03815 CERTIFICATE OF DEATH					
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		MABEL K. KEARNEY		4-17-72 1:31 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Bon Secours Hospital			A. STATE MD.		
			B. COUNTY		
			C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER 4128 FAIRVIEW AVE.		
5. SEX F	6. RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-09-01	9. AGE (In years last birthday) 71	If Under 1 Yr. Months Days If Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Md.	
13. FATHER'S NAME Edward Koch			14. MOTHER'S MAIDEN NAME Barbara Baldwin		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 215-12-2635		17. INFORMANT WALTER KEARNEY 4128 FAIRVIEW AVE	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ACUTE MYOCARDIAL INFARCTION (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH HOURS		
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). ASCVD & CHF			6 MONTHS		
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 4-17-72 to 4-17-72 that (I) (we) last saw the deceased alive on 4-17-72 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Oscar E. Fernandini M.D.				23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) OSCAR E. FERNANDINI M.D.				23D. ADDRESS 2025 W. FAYETTE ST. BALTO., MD.	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY	
BURIAL		4-21-72		NEW CATHEDRAL CEM BALTIMORE MARYLAND	
25A. DATE REC'D BY HEALTH DEPT. APR 20 1972		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR FURNER FUNERAL HOME 5311 EDMONDSON AVE	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				CERTIFICATE OF DEATH		REG. NO. <u>72 03816</u>	
BIRTH NO. <u>72 03816</u>		1. NAME OF DECEASED (Type or Print) <u>NIEDZWIECKI, JOSEPHINE R.</u>				2. DATE AND HOUR OF DEATH <u>APRIL 16, 1972</u> <u>11:20A</u> M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>40 ST. AGNES HOSPITAL</u>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence, before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>BALTO.</u> C. CITY OR TOWN <u>BALTIMORE</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>1003 VANDERWOOD RD. 21228</u>			
5. SEX <u>FEMALE</u>	6. RACE <u>CAUCASIAN</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12/14/00</u>	9. AGE (in years last birthday) <u>71</u>	II Under 1 Yr. Months Days II Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>NEW JERSEY</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>FRANK ADAMSKI</u>		14. MOTHER'S MAIDEN NAME <u>ROSE (SAWYCKI)</u>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>			
16. SOCIAL SECURITY NO. <u>140-09-2912</u>		17. INFORMANT <u>ST. AGNES' RECORDS</u>				ADDRESS <u>WILKENS & CATON AVE BALTO. MARYLAND</u>	
18. <u>486X I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <u>hemic coma</u> (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Severe rheumatoid arthritis</u>				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Pneumonia @ lung</u> (B) DUE TO, OR AS A CONSEQUENCE OF: (C)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>3 weeks</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>NO</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that <u>X</u> (this hospital) attended the deceased from <u>APRIL 13, 1972</u> to <u>APRIL 16, 1972</u> that <u>X (we)</u> last saw the deceased alive on <u>APRIL 16, 1972</u> and that in <u>my</u> (our) opinion death occurred on the date and hour and from the causes stated above. <u>X (We)</u> (did) (did not) view the body after death.							
23A. SIGNATURE <u>[Signature]</u> 23C. PHYSICIAN'S NAME (Type) <u>JOSE APTER M.D.</u>				23B. DATE SIGNED <u>4/16/72</u>		23D. ADDRESS <u>ST. AGNES HOSPITAL</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>4/20/72</u>		24C. NAME of CEMETERY or CREMATORY <u>HOLY CROSS CEMETERY N. ARLINGTON</u>		24D. LOCATION (City, town, or county) (State) <u>N. J.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>APR 20 1972</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor</u>		25C. FUNERAL DIRECTOR <u>WEBER FUNERAL HOME</u>		ADDRESS <u>5311 EDMONDSON AVE</u>	

1955, 11

1955, 11, 21

1955, 11, 21

1955, 11, 21

1955, 11, 21

1955, 11, 21

1955, 11, 21

1955, 11, 21

1955, 11, 21

1955, 11, 21

1955, 11, 21

1955, 11, 21

1955, 11, 21

1955, 11, 21

1955, 11, 21

1955, 11, 21

1955, 11, 21

1955, 11, 21

1955, 11, 21

1955, 11, 21

1955, 11, 21

1955, 11, 21

1955, 11, 21

1955, 11, 21

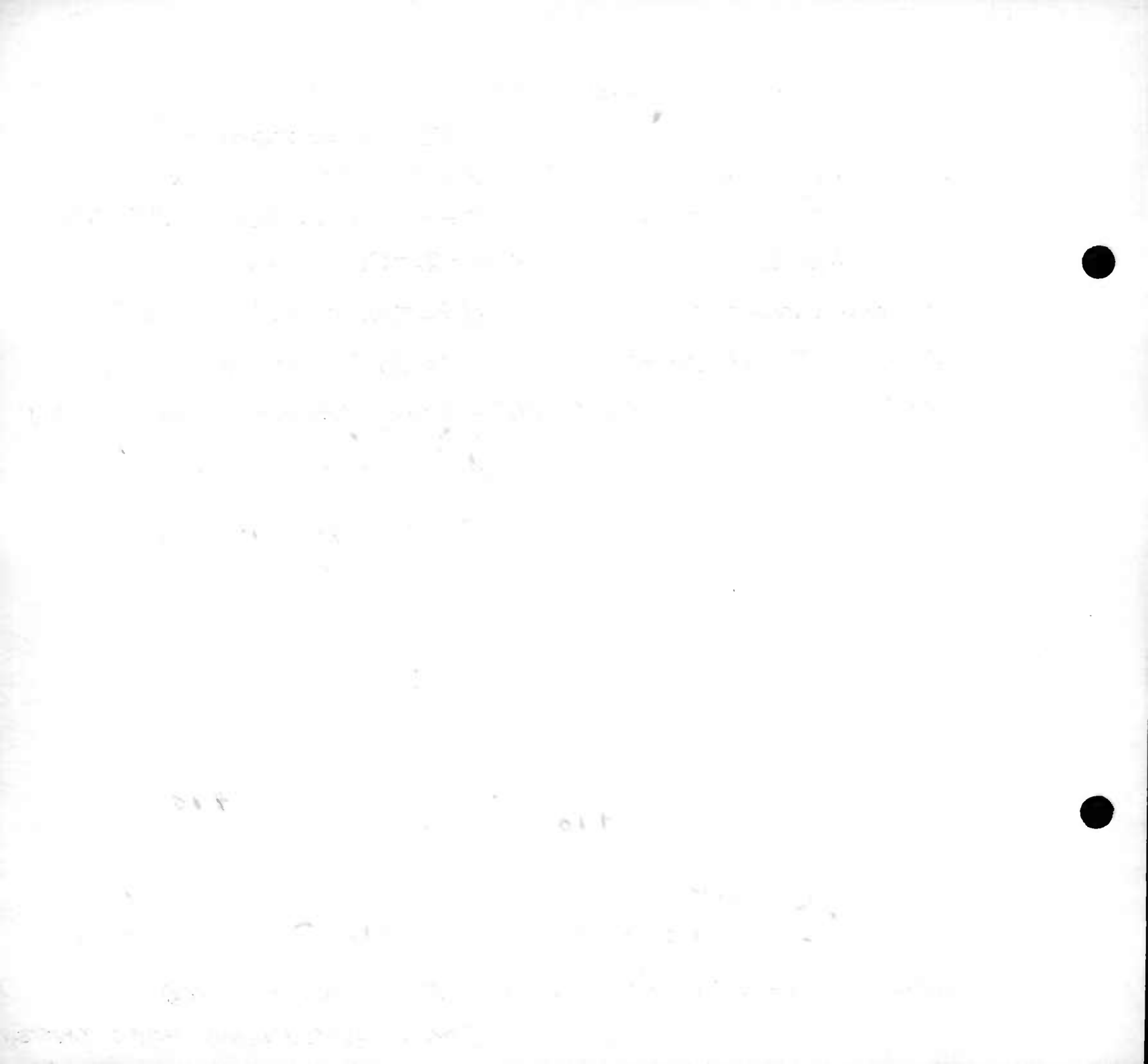
1955, 11, 21

1955, 11, 21

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 03817	
CERTIFICATE OF DEATH					
BIRTH NO. 72 03817					
1. NAME OF DECEASED (Type or Print) LOUIS M. WRIGHT		2. DATE AND HOUR OF DEATH 4-16-72			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE 748 S. CURLEY ST. 101 B. COUNTY			
FULL NAME OF HOSPITAL OR INSTITUTION MIDTOWN NURSING HOME 808 ST. PAUL ST.		C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX M		6. RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) COLUMBIA SPECIALIST		10B. KIND OF BUSINESS OR INDUSTRY		8. DATE OF BIRTH 2-2-06	
13. FATHER'S NAME JOHN T. WRIGHT		14. MOTHER'S MAIDEN NAME BARBARA FUKA		9. AGE (in years last birthday) 66	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 216-01-6395		17. INFORMANT LOUISE NAUMAN 748 S. CURLEY	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH 4369 1. This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death. 2. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH Bilateral Terminal Pneumonia A.S.C.V. Disease (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: CVA - Right Hemisphere (B) DUE TO, OR AS A CONSEQUENCE OF: (C)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 wks.	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 9/1/71 19 to 9/10 1972 that (I) (we) last saw the deceased alive on 9/10 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE J. S. Blum		23B. DATE SIGNED 4/17/72		23C. PHYSICIAN'S NAME (Type) J. S. BLUM MD	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 4-19-72		24C. NAME OF CEMETERY or CREMATORY HOLY REDEEMER BALTO. MD.	
25A. DATE REC'D BY HEALTH DEPT. APR 20 1972		25B. NAME OF REGISTRAR Robert E. Taylor, Jr.		25C. FUNERAL DIRECTOR JOHN M. WEBER & SONS 408 S. CHESTER	



B-250

72 03818

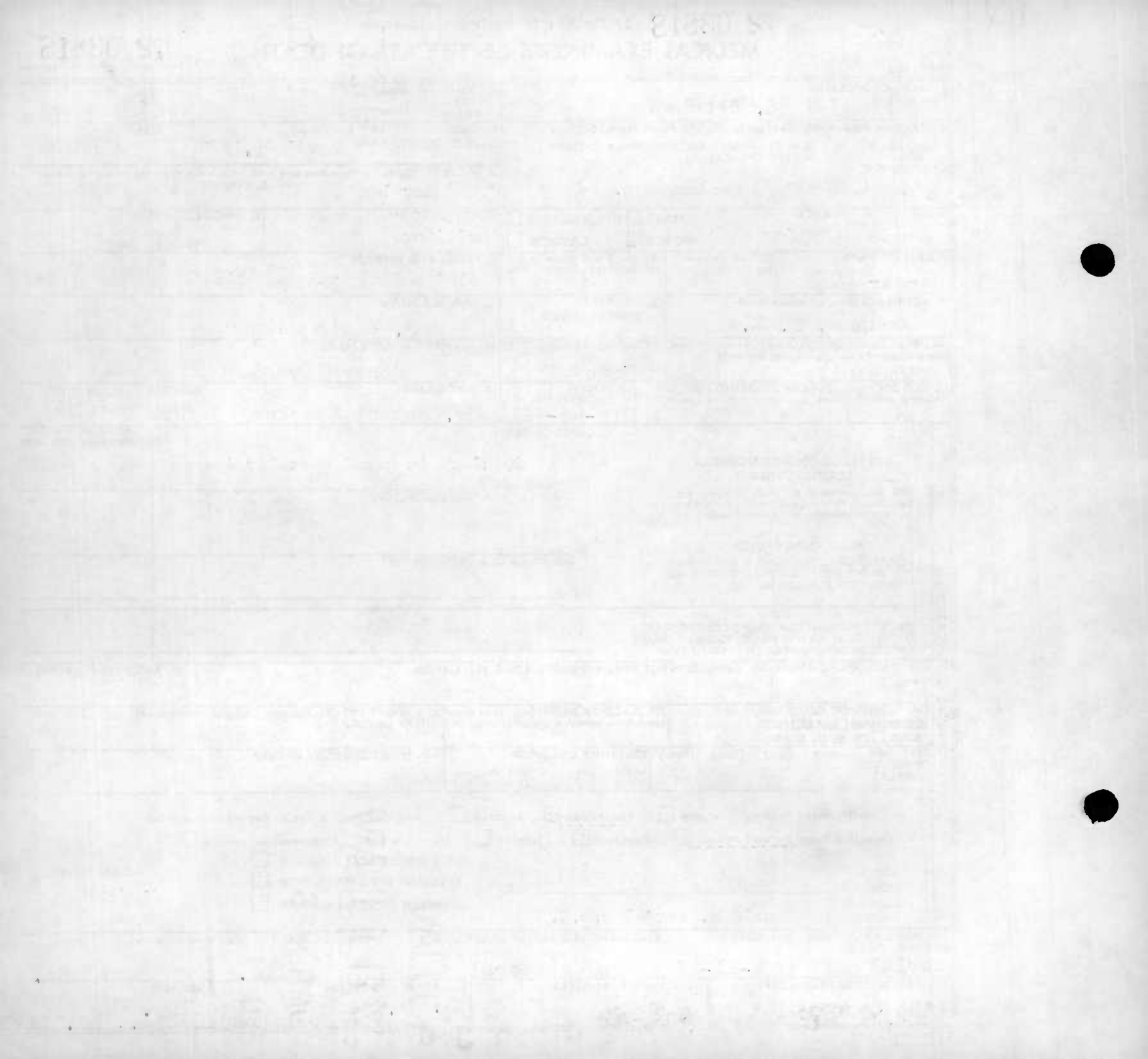
BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 72 03818

BIRTH NO.

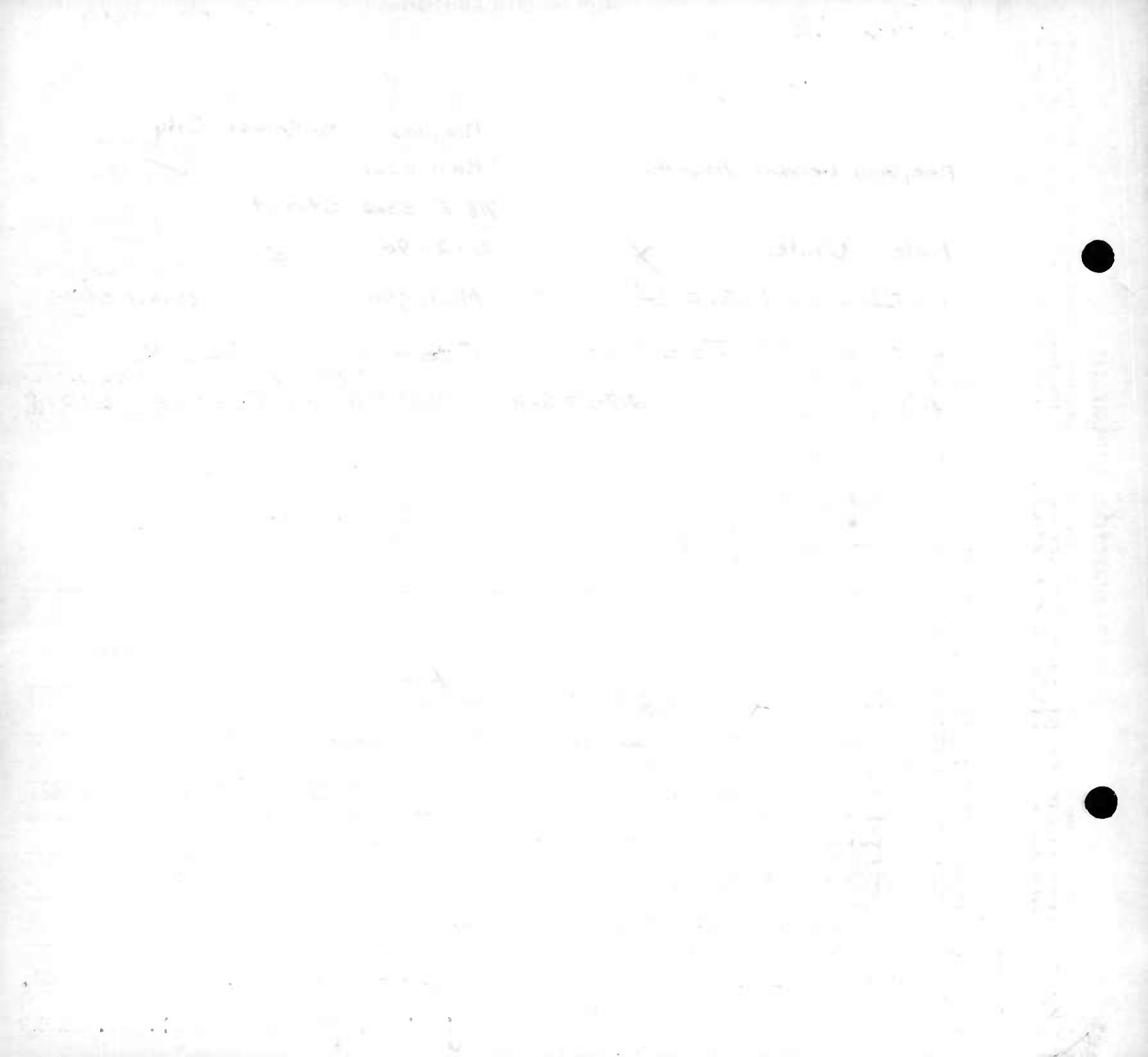
1. NAME OF DECEASED (Type or Print) RENA S. Beacham		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 00 4300 Roland Avenue, Apt. B-3		3. DATE PRONOUNCED DEAD Month Day Year Hour April 19, 1972 7:10 A. M.	
5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY 2714			
6. SEX Female	7. RACE White	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH 6-24-1895		10. AGE (In years lost birthday) 76 If Under 1 Yr. II Under 24 Hrs. Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) Orange, N. J.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME G. Edwin Sawyer		14. STREET AND NUMBER 4300 Roland Avenue 21210	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		14B. KIND OF BUSINESS OR INDUSTRY Own Home	
15. MOTHER'S MAIDEN NAME Geneva Trust		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No	
17. SOCIAL SECURITY NO. 216-46-5211		18. INFORMANT Mr. Robert Beacham	
19. CAUSE OF DEATH 412.41 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) NO			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?			
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Ronald N. Kornblum, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
DATE SIGNED 4/19/72			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4-21-72	
24C. NAME OF CEMETERY or CREMATORY New Cathedral		24D. LOCATION (City, town, or county) (State) Balto. Md.	
25A. DATE REC'D BY HEALTH DEPT. APR 20 1972		25B. NAME OF REGISTRAR Robert E. Jones, M.D.	
25C. FUNERAL DIRECTOR H. W. Jenkins & Sons Co.		ADDRESS 4905 York Road Balto., Md. 21211	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Bodily burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				CERTIFICATE OF DEATH		REG. NO. <u>72 03819</u>	
BIRTH NO. <u>T-140 72 03819</u>				1. NAME OF DECEASED (Type or Print) <u>Teepie, Kenneth S.</u>		2. DATE AND HOUR OF DEATH <u>4-20-72</u> <u>1:30 A.M.</u>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore City</u>		C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
FULL NAME OF HOSPITAL OR INSTITUTION <u>Maryland General Hospital</u> IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION				E. STREET AND NUMBER <u>718 E. 33RD STREET</u>			
5. SEX <u>Male</u>	6. RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-2-96</u>	9. AGE (in years last birthday) <u>76</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED - U.S. F.G. FINANCIAL</u>				11. BIRTHPLACE (State or foreign country) <u>Michigan</u>		12. CITIZEN OF WHAT COUNTRY? <u>United States</u>	
13. FATHER'S NAME <u>LLOYD M. TEEPLE</u>				14. MOTHER'S MAIDEN NAME <u>ELLA M. SIGLER</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service <u>No</u>				16. SOCIAL SECURITY NO. <u>217-07-8231A</u>		17. INFORMANT <u>1539 E. GOLD SPRING LANE</u> <u>WARREN K. TEEPLE</u> ADDRESS <u>21218</u>	
18. <u>412.41</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Multiple Rhythm Disturbance</u> (B) DUE TO, OR AS A CONSEQUENCE OF: <u>ASCVD</u> (C) <u>2 mo.</u> <u>2 yrs.</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>3-27</u> 19 <u>72</u> to <u>4-20</u> 19 <u>72</u> that (I) (we) last saw the deceased alive on <u>4-19</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.							
23A. SIGNATURE <u>Henry G. Sacks</u>				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>4-20-72</u>	
23C. PHYSICIAN'S NAME (Type) <u>HENRY G. SACKS</u>				23D. ADDRESS <u>MD. GEN. Hosp.</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>4-22-72</u>		24C. NAME OF CEMETERY or CREMATORY <u>Dulaney Valley Memorial Gardens</u>		24D. LOCATION (City, town, or county) (State) <u>Timonium, Md.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>APR 20 1972</u>		25B. NAME OF REGISTRAR <u>John E. Taylor, M.D.</u>		25C. FUNERAL DIRECTOR <u>H. W. Jenkins & Sons Co.</u>		ADDRESS <u>4905 York Road Balto., Md. 21212</u>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				72 03820
CERTIFICATE OF DEATH				REG. NO. _____
BIRTH NO. <u>W-640</u>		72 03820		
1. NAME OF DECEASED (Type or Print) <u>WEHRLE, HENRY C.</u>		2. DATE AND HOUR OF DEATH <u>4/15/72</u> <u>8:30</u> P.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MD.</u> B. COUNTY <u>2006</u>		
FULL NAME OF HOSPITAL OR INSTITUTION <u>MARYLAND GENERAL HOSPITAL</u> <u>48</u>		C. CITY OR TOWN <u>BALTIMORE</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
E. STREET AND NUMBER <u>3240 KINGSLEY ST.</u>				
5. SEX <u>MALE</u>	6. RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11/28/87</u>	9. AGE (In years lost birthday) <u>84</u> If Under 1 Yr. Months: Oays: If Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Baltimore Transit</u>		11. BIRTHPLACE (State or foreign country) <u>PENNSYLVANIA</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME		
14. MOTHER'S MAIDEN NAME				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>213-10-0853</u>		17. INFORMANT <u>Mrs Cathryn A. Thompson</u> ADDRESS <u>3240 Kingsley St.</u>
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>Acute coronary artery thrombosis</u> <u>MYOCARDIAL INFARCTION</u> <u>6 hrs.</u>		CAUSE OF DEATH APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>II</u> <u>Atherosclerotic cardiovascular disease</u> <u>CANCER OF PROSTATE</u> <u>1 yr.</u>		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <u>Pulmonary lymph node carcinoma of prostate</u>				
19A. DATE OF OPERATION <u>3/13/72</u>	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>CA, prostate</u>	20A. AUTOPSY? (Yes or No) <u>Yes</u>	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>Yes</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?		
22. I certify that (this hospital) attended the deceased from <u>6 April 1972</u> to <u>15 April 1972</u> that (we) last saw the deceased alive on <u>April 15 1972</u> and that in (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.				
23A. SIGNATURE <u>Gregory Bruce</u>		23B. DATE SIGNED <u>15 April 72</u>		23C. PHYSICIAN'S NAME (Type) <u>Gregory Bruce</u>
23D. ADDRESS <u>Gregory Bruce</u>				
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>	24B. DATE <u>4/19/1972</u>	24C. NAME OF CEMETERY OR CREMATORY <u>Loudon Park Cemetery</u>	24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>APR 20 1972</u>	25B. NAME OF REGISTRAR <u>Robert E. Taylor, M.D.</u>	25C. FUNERAL DIRECTOR ADDRESS <u>G. Truman Schwab 3512 Frederick Ave.</u>		

N-425 72 03821

BALTIMORE CITY HEALTH DEPARTMENT

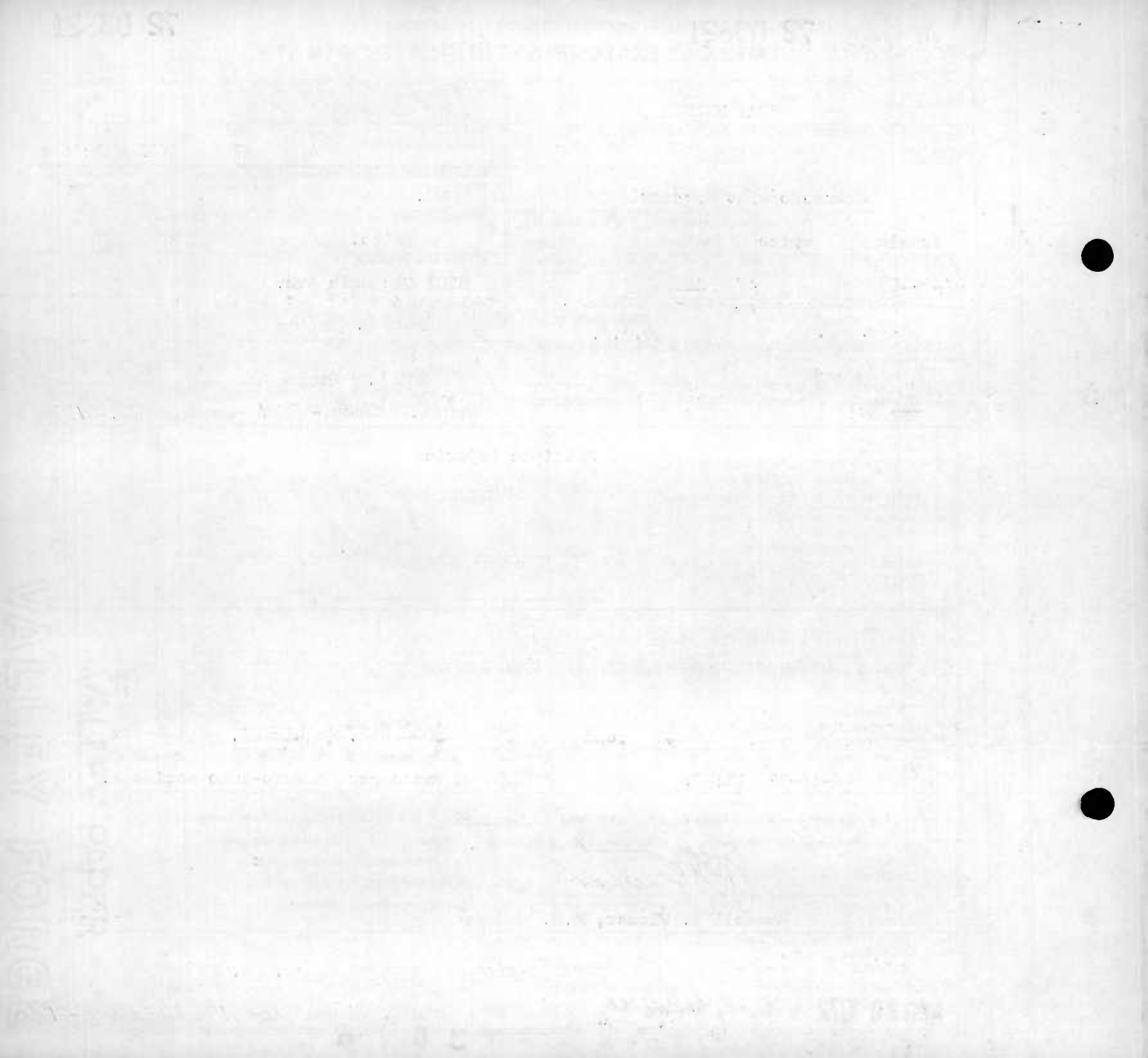
72 03821

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

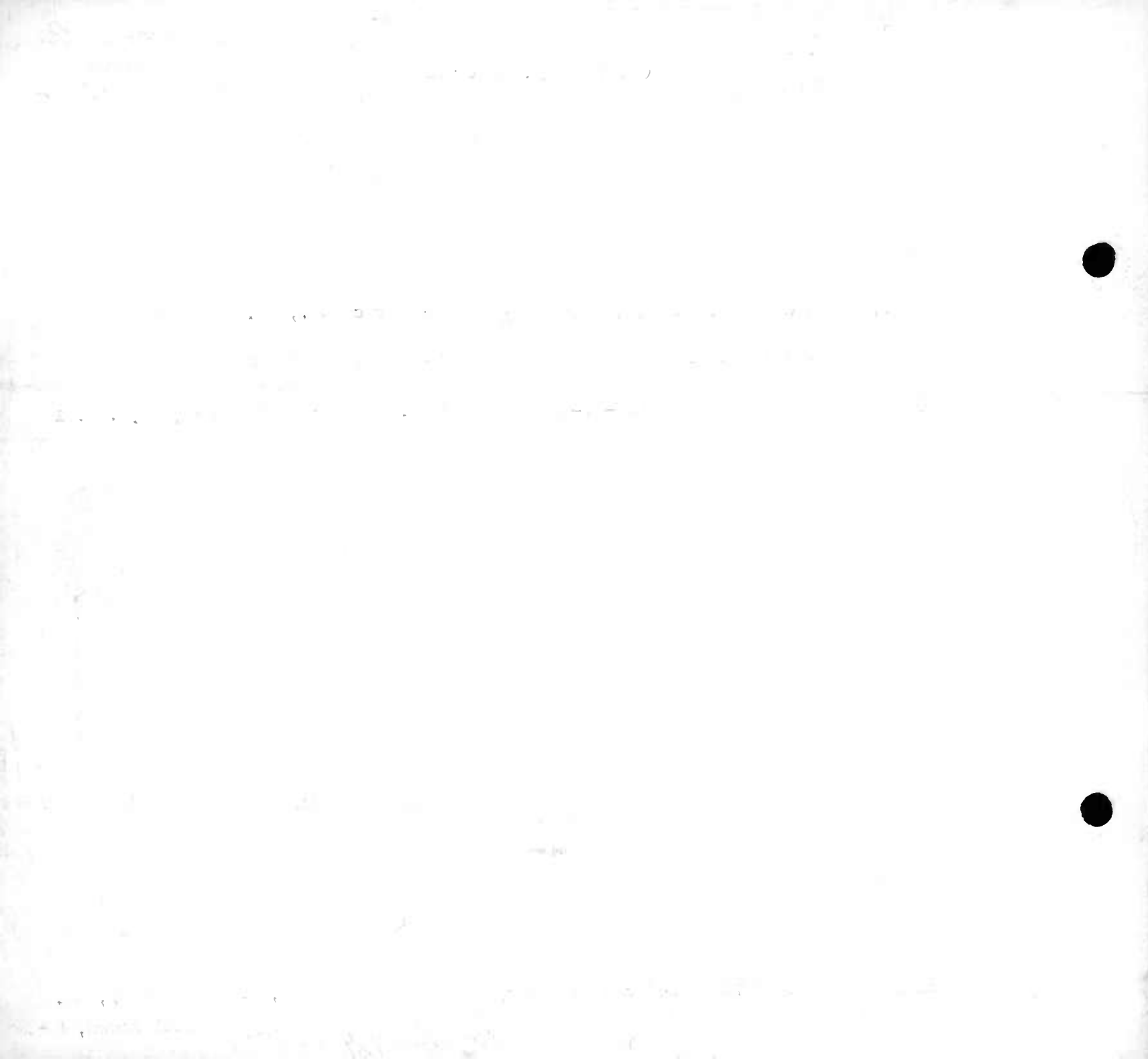
1. NAME OF DECEASED (Type or Print) DEBRA NELSON		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 33 Johns Hopkins Hospital		3. DATE PRONOUNCED DEAD Month Day Year Hour 4 17 1972 12:46 a.m.	
5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY 2735		C. CITY OR TOWN Balto. D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
6. SEX female	7. RACE white	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH 1-29-54		10. AGE (In years last birthday) 18 19 If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) Balto. Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Henry G. Nelson		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student	
15. MOTHER'S MAIDEN NAME Mary C. Clark		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no	
17. SOCIAL SECURITY NO.		18. INFORMANT Henry G. Nelson - 3201 Glendale Ave. - 21234	
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) E812.1 ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		CAUSE OF DEATH Multiple injuries (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:	
20. DATE OF OPERATION 2		21. AUTOPSY? (Yes or No) yes	
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) road	
22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 6000 blk. Belair Rd. 2734		22D. TIME OF INJURY (APPROX.) 4-16-72 11:47p	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? Passenger in auto-auto accident.	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Russell S. Fisher, M.D. CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED 4-17-72 EXAMINER'S NAME (Type) Russell S. Fisher, M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4-20-72	
24C. NAME OF CEMETERY or CREMATORY Parkwood Cemetery		24D. LOCATION (City, town, or county) (State) Balto. Md.	
25A. DATE REC'D BY HEALTH DEPT. APR 20 1972		25B. NAME OF REGISTRAR Robert E. Fisher, M.D.	
25C. FUNERAL DIRECTOR John C. Miller Inc-6415 Belair Road-21206		25D. ADDRESS	



FUNERAL DIRECTOR: IMPORTANT

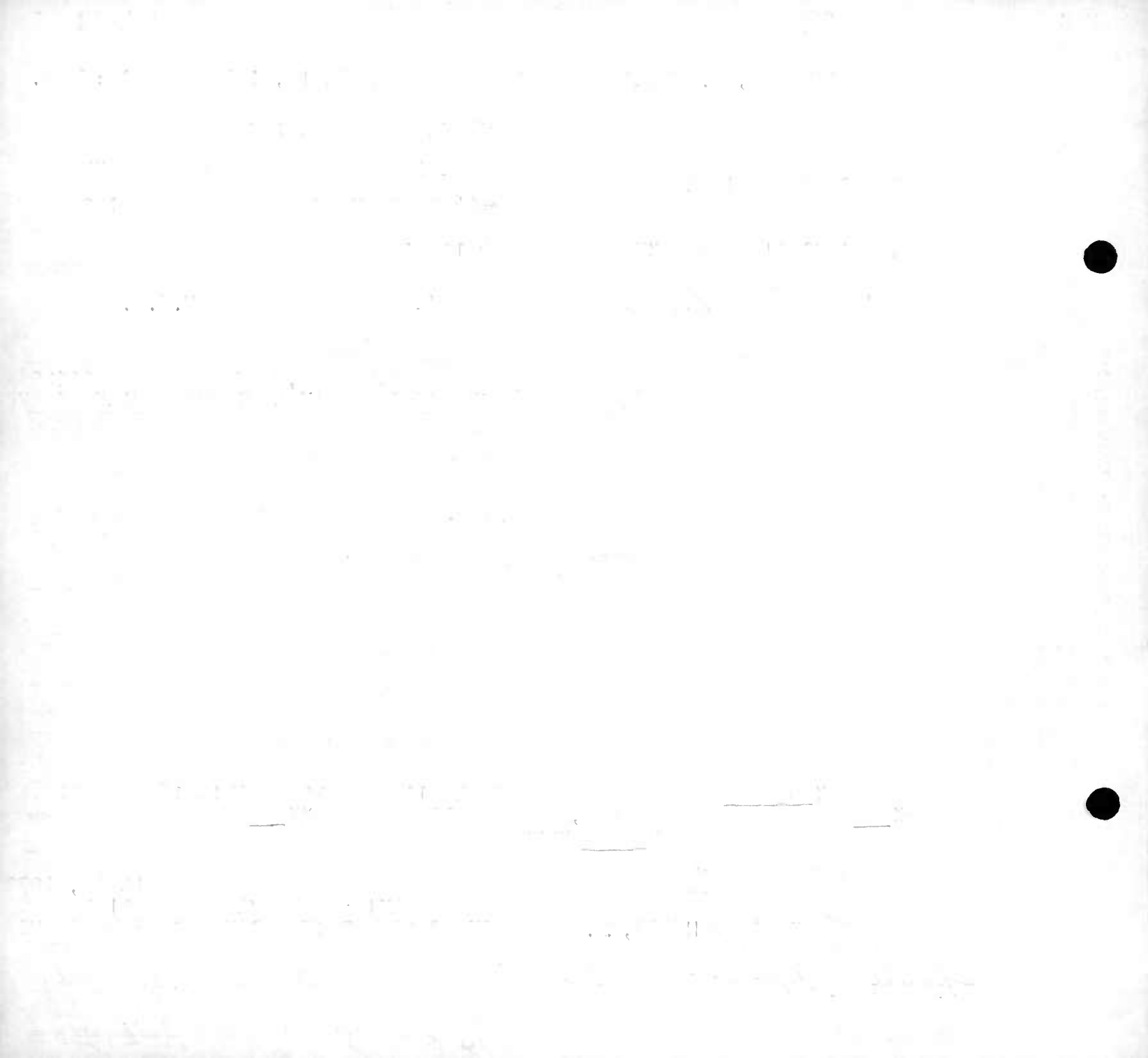
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Baltimore City Health Department				REG. NO.	
W-356 72 03822		72 03822		72 03822	
BIRTH NO.		NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		Sterling Whitmore (Sterling J. Whitmore)		4/18/72 12:15 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE B. COUNTY			
38 University of Maryland Hospital Baltimore, Md.		Md. Carroll 5600			
		C. CITY OR TOWN		D. INSIDE CITY LIMITS?	
		Finksburg 21048		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
		E. STREET AND NUMBER			
		Rt. 1			
5. SEX	6. RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. If Under 1 Yr. Months Days
M	W	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	1-16-01	71	11. If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Laborer, Congoleum Plant		Congoleum Industry		Frederick Co., Md.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
William Walter Whitmore		Martha Ellen Thompson		U.S.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
No		216-07-4190		Robert S. Whitmore, Finksburg, Md. R. D. 1	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH			
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
ANTECEDENT CAUSES		Congestive Heart Failure			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) Renal Failure			
		(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		Respiratory Insufficiency			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
				NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
(Month) (Day) (Year) (Hour)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from 4/6 19 72 to 4/18 19 72 that (I) (we) last saw the deceased alive on 4/17 19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE		23B. DATE SIGNED			
Robert E. Greenspan M.D.		4/18/72			
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
Robert E. Greenspan M.D.		829 Hollins St. Baltimore, Md.			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY	
Burial		4/20/72		Reformed Cemetery	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
APR 20 1972		Robert E. Greenspan, M.D.		Richard A. Little Littlestown, PA.	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				X REG. NO. 72 03823	
BIRTH NO. 8-100 72 03823		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) SCHWAAB, SR. WILLIAM HENRY			2. DATE AND HOUR OF DEATH APRIL 18, 1972 10:00 P.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 40 ST AGNES HOSPITAL			4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER 466 KENT AVENUE 21228		
5. SEX MALE	6. RACE CAUCASIAN	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/11/93	9. AGE (In years last birthday) 79	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) JANITOR		10B. KIND OF BUSINESS OR INDUSTRY Apt. Bldg.	11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME unknown			14. MOTHER'S MAIDEN NAME unknown		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 218-10-4795	17. INFORMANT BALTIMORE, MARYLAND ADDRESS 21229 ST AGNES HOSPITAL CATON & WILKENS AVE		
18. 433.91 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. CAUSE OF DEATH (A) IMMEDIATE CAUSE Pulmonary Embolism DUE TO, OR AS A CONSEQUENCE OF: (B) Right Hemiparesis due to thrombosis affecting. (C) Left Internal Capsule.			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (X) (this hospital) attended the deceased from APRIL 11 1972 to APRIL 18 1972 that (X) (we) last saw the deceased alive on APRIL 18 1972 and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (XXXX) view the body after death.					
23A. SIGNATURE TARIQ MAHMOOD, MD.				23B. DATE SIGNED APRIL 18, 1972	
23C. PHYSICIAN'S NAME (Type) TARIQ MAHMOOD, MD.				23D. ADDRESS BALTIMORE MARYLAND 21229 ST AGNES HOSPITAL CATON & WILKENS AVE	
24A. BURIAL CREMATION, REMOVAL (Specify) burial		24B. DATE 4/22/72		24C. NAME OF CEMETERY OR CREMATORY Cedar Hill Cem.	
24D. LOCATION G.A. Co. Bays, Md.		24E. STATE Md.		24F. CITY, TOWN, OR COUNTY Baltimore	
25A. DATE REC'D BY HEALTH DEPT. APR 20 1972		25B. NAME OF REGISTRAR Robert E. Zuber, Jr.		25C. FUNERAL DIRECTOR John F. Conway & Son, Inc.	
25D. ADDRESS 901 Hollings St		25E. CITY, TOWN, OR COUNTY Baltimore		25F. STATE Md.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

C-450 72 03824				BALTIMORE CITY HEALTH DEPT.		CERTIFICATE OF DEATH		REG. NO. 72 03824	
1. NAME OF DECEASED (Type or Print) Robert J. Cluney				2. DATE AND HOUR OF DEATH April 19, 1972					
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY 2403					
FULL NAME OF HOSPITAL OR INSTITUTION 00		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 1290 Battery Avenue		C. CITY OR TOWN Baltimore 21230		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
5. SEX Male		6. RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Mar. 19, 1898		9. AGE (In years last birthday) 74	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Maintenance		10B. KIND OF BUSINESS OR INDUSTRY City Hospitals		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Robert F. Cluney				14. MOTHER'S MAIDEN NAME Mary Hayes					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service No		16. SOCIAL SECURITY NO. 214 40 6303		17. INFORMANT John J. Cluney		ADDRESS 426 Seward Avenue Brooklyn, Maryland 21225			
18. 4/12/72 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Probable acute MI - arrhythmia				CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 min.			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Chronic obstructive lung disease				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: ASCVD -		(B) DUE TO, OR AS A CONSEQUENCE OF: 4 yrs			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				(C) DUE TO, OR AS A CONSEQUENCE OF: 4 yrs -					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (1) (this hospital) attended the deceased from 3/2 19 71 to 4/19 19 72 that (1) (we) last saw the deceased alive on 4/14 19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (1) (We) (did) (did not) view the body after death.									
23A. SIGNATURE E. L. Robbins M.D.				DEGREE		23B. DATE SIGNED 4/19/72			
23C. PHYSICIAN'S NAME (Type) E. L. Robbins, M.D.				DEGREE		23D. ADDRESS Mercy Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4-22-72		24C. NAME of CEMETERY or CREMATORY New Cathedral Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland			
25A. DATE REC'D BY HEALTH DEPT. APR 20 1972		25B. NAME OF REGISTRAR Robt E. Cluney, Jr.		25C. FUNERAL DIRECTOR McGulley Funeral Home		ADDRESS 130 East Fort Avenue Balto., Md. 21230			

1911

1911

1911

1911

1911

1911

1911

1911

1911

1911

1911

1911

1911

1911

1911

1911

1911

1911

1911

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>72 03825</u>	
B-652 BIRTH NO. 72 03825		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <u>XXX Brannock, Washington Paul</u>			2. DATE AND HOUR OF DEATH <u>4-18-72</u> <u>10:10 P.M.</u>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <u>Mercy Hospital</u> (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>37</u>			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>2301</u> C. CITY OR TOWN <u>Baltimore</u> <u>21230</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>23 West West Street</u>		
5. SEX <u>male</u>	6. RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-30-98</u>	9. AGE (In years last birthday) <u>73</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>truck driver</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			13. FATHER'S NAME <u>William Brannock</u>		
14. MOTHER'S MAIDEN NAME <u>Eliza Mayville</u>			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		
16. SOCIAL SECURITY NO. <u>212 07 9904</u>		17. INFORMANT <u>Fannie E. Brannock</u> <u>23 W. West Street Balto., Md. 21230</u>			
18. CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>(A) IMMEDIATE CAUSE</u> <u>Cardio-vascular</u> <u>DUE TO, OR AS A CONSEQUENCE OF:</u> <u>(B) Hypertension</u> <u>DUE TO, OR AS A CONSEQUENCE OF:</u> <u>(C) Metastatic Ad Lung</u>					
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		(If in Baltimore City, give exact location)			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR?	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>4/16</u> 19 <u>72</u> to <u>4/18</u> 19 <u>72</u> that (I) (we) last saw the deceased alive on <u>4/18</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>M. V. Chilton</u>			23B. DATE SIGNED <u>4/19/72</u>		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>
23C. PHYSICIAN'S NAME (Type) <u>M. E. Goldstein</u>			23D. ADDRESS <u>Mercy Hosp, Balto., Md.</u>		
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>4-22-72</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Glen Haven Memorial Park</u>	
24D. LOCATION (City, town, or county) (State) <u>Glen Burnie, Maryland</u>		25A. DATE RECD BY HEALTH DEPT. <u>APR 20 1972</u>			
25B. NAME OF REGISTRAR <u>Robert E. Taylor</u>		25C. FUNERAL DIRECTOR <u>McCurly Funeral Home</u> <u>130 East Fort Avenue Balto., Md. 21230</u>			

1901

1902

1903

x

1904

...

1905

1906

1907

1908

1909

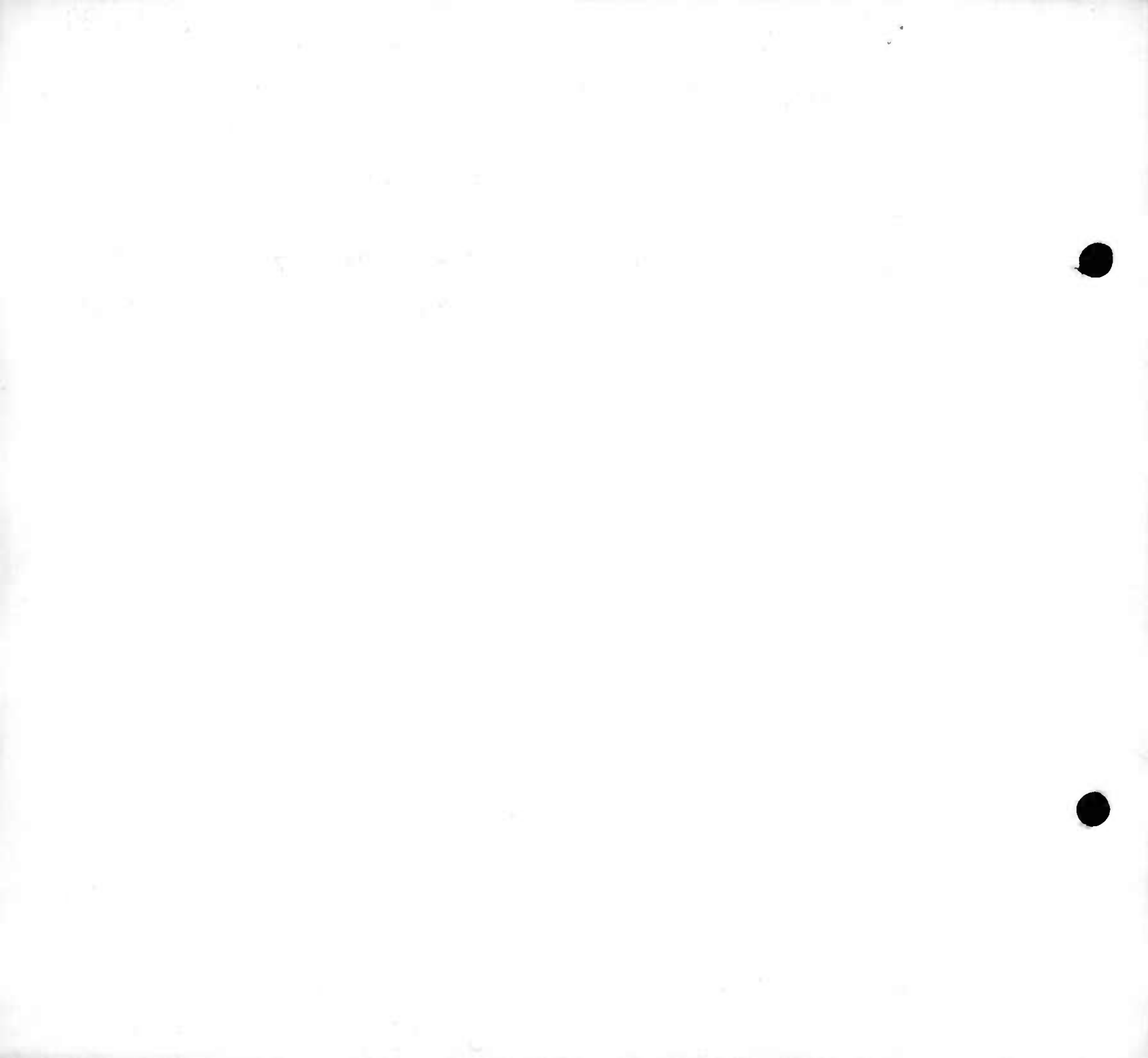
1910

1911

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-424 72 03826		BALTIMORE CITY HEALTH DEPARTMENTS CERTIFICATE OF DEATH		REG. NO. 42-77-082 03826
1. NAME OF DECEASED (Type or Print) BALSLEY, ROSA M		2. DATE AND HOUR OF DEATH 04-18-72 11:45 P.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MD B. COUNTY CALVERT 5300		
FULL NAME OF HOSPITAL OR INSTITUTION 38 UNIVERSITY OF MARYLAND HOSP. BALD.		C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		E. STREET AND NUMBER 204 N. ROLLING RD		
5. SEX FEMALE	6. RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 03-28-93	9. AGE (In years last birthday) 79
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WIFE		10B. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY USA		13. FATHER'S NAME ARTHUR C. BEEFELT		
14. MOTHER'S MAIDEN NAME ALICE SMITH		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		
16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS		
18. CAUSE OF DEATH				
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 157.91				
(A) IMMEDIATE CAUSE METASTATIC CA OF PANCREAS DUE TO, OR AS A CONSEQUENCE OF:				
(B) DUE TO, OR AS A CONSEQUENCE OF:				
(C) DUE TO, OR AS A CONSEQUENCE OF:				
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				
19A. DATE OF OPERATION 04-04-72		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED CA HEAD OF PANCREAS		20A. AUTOPSY? (Yes or No) -
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from 04-18-72 19 72 to 04-18-72 19 72 and that (I) (we) last saw the deceased alive on 04-18-72 19 72 and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <i>Gustavo R. Roca</i>				23B. DATE SIGNED 04-18-72
23C. PHYSICIAN'S NAME (Type) GUSTAVO R. ROCA		23D. ADDRESS UNIVERSITY HOSPITAL		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4/21/72		24C. NAME OF CEMETERY OR CREMATORY Lorraine Park Mausoleum
24D. LOCATION (City, town, or county) Baltimore, Maryland		25A. DATE REC'D BY HEALTH DEPT. APR 20 1972		
25B. NAME OF REGISTRAR John E. Smith		25C. FUNERAL DIRECTOR Witzke, 1630 Edmondson Avenue 21228		



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 03827	
BIRTH NO. 72 03827				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <u>Wood, Mary</u>			2. DATE AND HOUR OF DEATH <u>April 19 1972 2:00 P.M.</u>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>Sinai Hosp. of Baltimore, Md.</u>			A. STATE <u>Md.</u> B. COUNTY <u>2844</u>		
CERTIFICATE AMENDED <u>Since Hosp. of Baltimore, Md. 4-28-72</u>			C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER <u>4232 Flowerton Road</u>		
5. SEX <u>F</u>	6. RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6-21-85</u>	9. AGE (In years last birthday) <u>86</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME <u>Francis Keefer</u>			14. MOTHER'S MAIDEN NAME <u>Mary Satter Zoeller</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS <u>Walter E. Price Jr. 625 Braeside Rd. 21229</u>		
18. <u>41231</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>Fract. pulmonary edema</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>Cardiac arrhythmia</u> DUE TO, OR AS A CONSEQUENCE OF: (C) <u>Coronary sclerotic heart disease</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 hrs.</u> <u>4 hrs.</u> <u>20 hrs.</u>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>NO</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from <u>April 4 19 72</u> to <u>April 19 19 72</u> that (1) (we) last saw the deceased alive on <u>April 19 19 72</u> and that (in (my) (our) opinion) death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Jack Polloch M.D.</u>				23B. DATE SIGNED <u>April 19, 1972</u>	
23C. PHYSICIAN'S NAME (Type) <u>Jack Polloch M.D.</u>				23D. ADDRESS	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>4/21/72</u>		24C. NAME OF CEMETERY or CREMATORY <u>Lorraine Park</u>	
24D. LOCATION <u>Woodlawn, Maryland</u>		24E. DATE REC'D BY HEALTH DEPT. <u>APR 20 1972</u>			
24F. NAME OF REGISTRAR <u>Robert E. Taylor, No. 2</u>		24G. FUNERAL DIRECTOR <u>Witzke, 21630</u>		24H. ADDRESS <u>Edmondson Avenue 21228</u>	

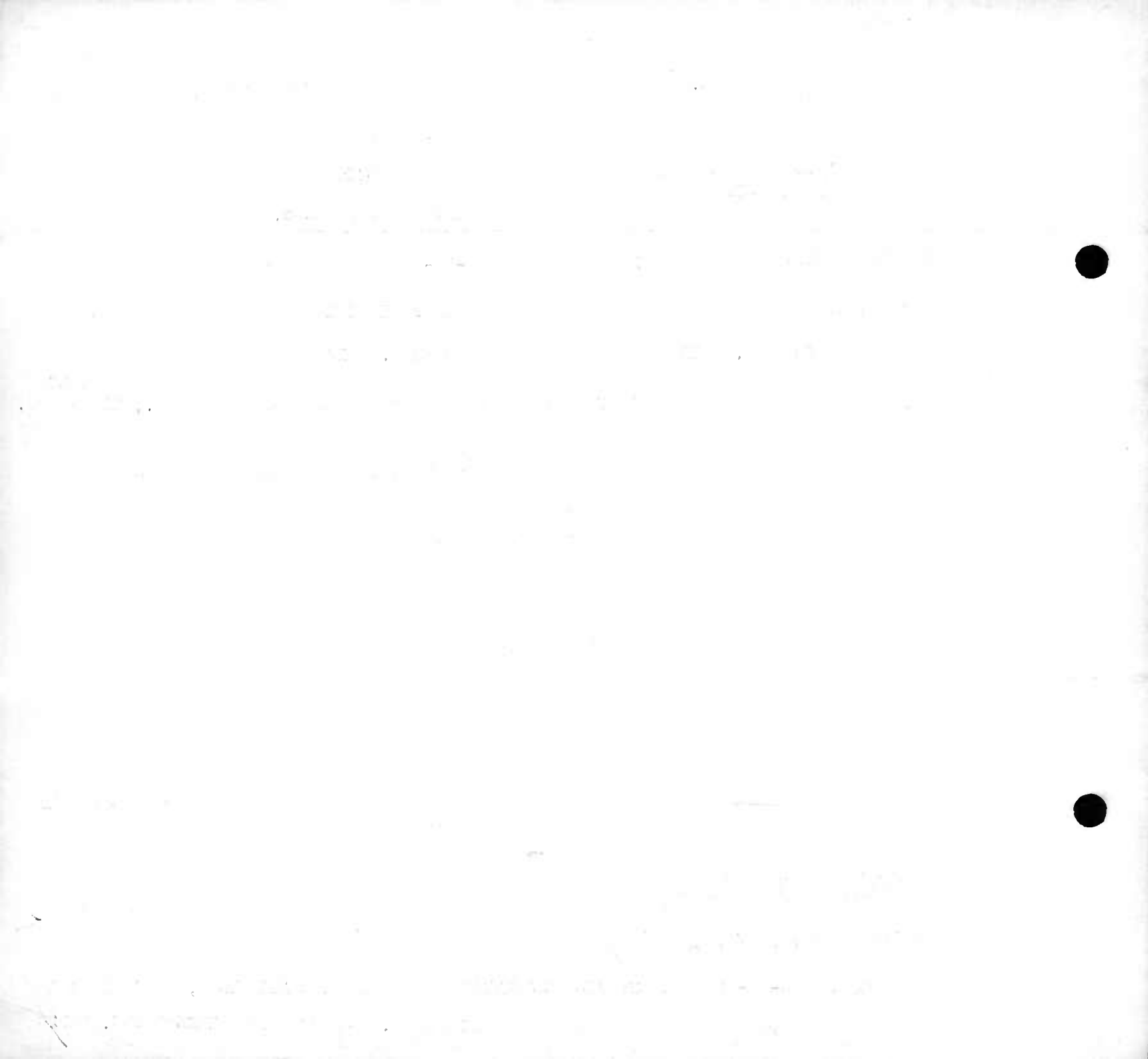
4-28-1972 - Correction Form from Funeral Director- Witzke, 1630 Edmondson Ave., Balto., Md.

HRS

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH										REG. NO. <u>72 03828</u>	
BIRTH NO. <u>6-650 72 03828</u>											
1. NAME OF DECEASED (Type or Print) <u>Zelma D. GRIMM</u>					2. DATE AND HOUR OF DEATH <u>4/19/72</u> <u>7:15</u> A.M.						
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>90</u> <u>GOULD CONVALESARIUM</u> <u>6116 BELAIR ROAD</u>					4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>2758</u> C. CITY OR TOWN <u>BALTIMORE</u> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>1523 Sherwood Ave.</u>						
5. SEX <u>FEMALE</u>		6. RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>8-27-89</u>		9. AGE (In years last birthday) <u>82</u>		If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOMEMAKER</u>					10B. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country) <u>WEST VIRGINIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>ANTHONY W. SMITH</u>					14. MOTHER'S MAIDEN NAME <u>MARY M. SMITH</u>						
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>					16. SOCIAL SECURITY NO. <u>215368349</u>		17. INFORMANT <u>KENNETH GRIMM 1523 SHERWOOD AVE., 21239 MD.</u>				
18. <u>4/12/72</u> I <u>I</u> CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>II</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <u>Hypertension (Old Status); Chronic Urinary Tract Infection</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>—</u>	
19A. DATE OF OPERATION			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from <u>3/28/72</u> 19 <u>72</u> to <u>4/19/72</u> that (I) (we) last saw the deceased alive on <u>4/14/72</u> 19 <u>72</u> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.											
23A. SIGNATURE <u>Albert B Bradley</u>					23B. DATE SIGNED <u>4/19/72</u>						
23C. PHYSICIAN'S NAME (Type) <u>ALBERT B BRADLEY</u>					23D. ADDRESS <u>HOWARD H. HUBBARD 4107 WILKENS AVE. 21229</u>						
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>			24B. DATE <u>4-22-72</u>		24C. NAME OF CEMETERY OR CREMATORY <u>NORTH VIEW CEMETERY</u>			24D. LOCATION (City, town, or county) (State) <u>NEW MARTINSVILLE, WEST VIRGINIA</u>			
25A. DATE REC'D BY HEALTH DEPT. <u>APR 21 1972</u>					25B. NAME OF REGISTRAR <u>Robert E. Taylor, R.D.</u>		25C. FUNERAL DIRECTOR <u>HOWARD H. HUBBARD</u>				



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

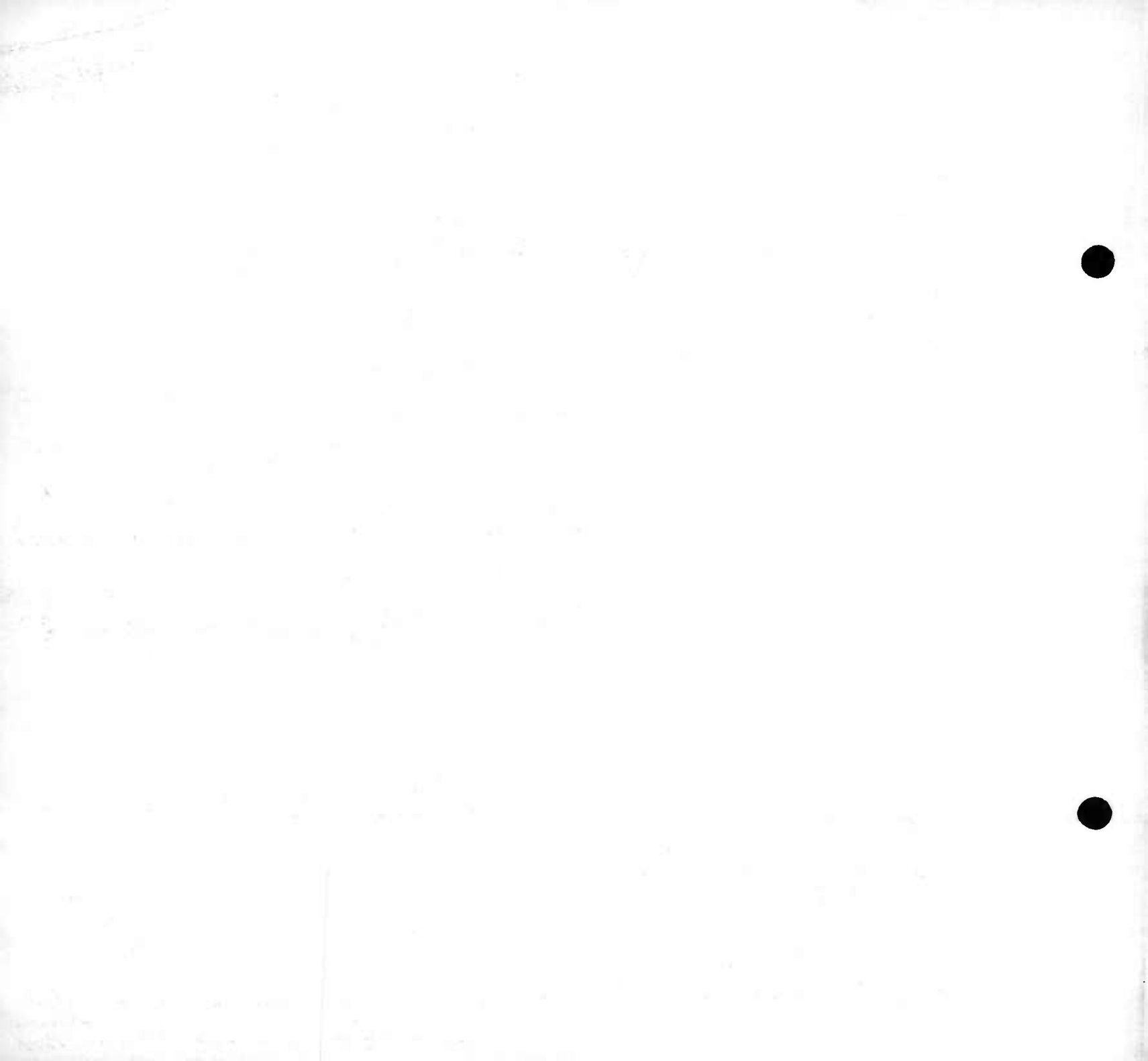
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>72 03829</u>	
BIRTH NO. <u>W-320 72 03829</u>		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <u>CATHERINE A. WATTS.</u>			2. DATE AND HOUR OF DEATH <u>4. 10. 72</u> <u>1:10 P M.</u>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, If institution; residence before admission) A. STATE <u>ANNE - ARUNDALE.</u> B. COUNTY <u>HANOVER.</u> C. CITY OR TOWN <u>RT 2. Box 175.</u> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER <u>5200</u>		
FULL-NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>Church Home & Hospital.</u>					
5. SEX <u>F</u>	6. RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11. 28. 99.</u>	9. AGE (In years last birthday) <u>72</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ret. Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	11. BIRTHPLACE (State or foreign country) <u>WASH. D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>WILLIAM B. HALE.</u>			14. MOTHER'S MAIDEN NAME <u>LAURA KINZER.</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>216 18 6886</u>	17. INFORMANT <u>Hospital chart.</u>		
18. <u>250.9 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>II</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>UNKNOWN</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>DIABETES</u> DUE TO, OR AS A CONSEQUENCE OF: (C) <u>ASCVD</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>long-standing</u>
MEDICAL CERTIFICATION					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>4. 4. 72</u> 19 <u>72</u> to <u>4. 10. 19 72</u> that (I) (we) last saw the deceased alive on <u>4. 10. 19 72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Satpal Singh</u>			23B. DATE SIGNED <u>4. 10. 72.</u>		
23C. PHYSICIAN'S NAME (Type) <u>SATPAL SINGH M.D.</u>			23D. ADDRESS <u>Church Home & Hospital.</u>		
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
<u>Burial</u>		<u>4/12/72</u>		<u>Madamridge Mem Park</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>APR 21 1972</u>		25B. NAME OF REGISTRAR <u>Robert E. Fisher, M.D.</u>		25C. FUNERAL DIRECTOR <u>Harold J. H.</u>	
				ADDRESS <u>Darkey, Md.</u>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

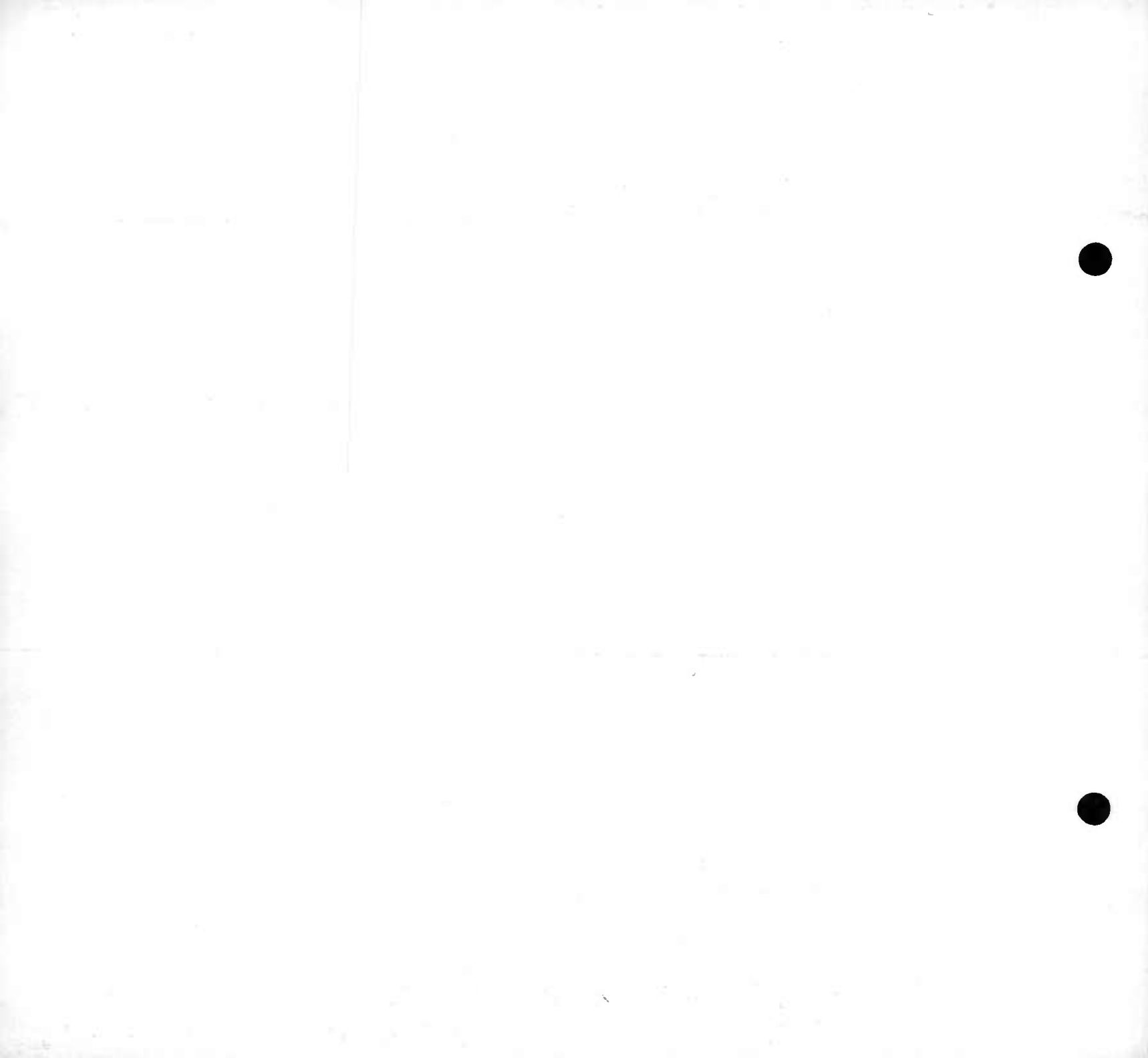
BALTIMORE CITY HEALTH DEPARTMENT											
CERTIFICATE OF DEATH											
BIRTH NO.		72 03830		REG. NO.		72 03830					
1. NAME OF DECEASED (Type or Print) <u>Wheeler, Joseph</u>				2. DATE AND HOUR OF DEATH <u>4/7/72</u> <u>6:30</u> P. M.							
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Md.</u> B. COUNTY <u>Howard</u>				6. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
FULL NAME OF HOSPITAL OR INSTITUTION <u>George Washington Nursing Home</u> <u>607 Pennsylvania ave.</u>				C. CITY OR TOWN <u>Jessup</u>				E. STREET AND NUMBER <u>Post Office Box 608</u>			
5. SEX <u>male</u>		6. RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>12/17/97</u>		9. AGE (in years last birthday) <u>74</u>		If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Painter</u>				11. BIRTHPLACE (State or foreign country) <u>SAVAGE, Md.</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>			
13. FATHER'S NAME <u>Sim Wheeler</u>				14. MOTHER'S MAIDEN NAME <u>Birdie</u>				15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>Unknown</u>			
16. SOCIAL SECURITY NO. <u>216-32-6941</u>				17. INFORMANT <u>Chart</u>				ADDRESS <u>607 Pennsylvania</u>			
18. <u>440.91</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH <u>GENERALIZED ARTERIOSCLEROSIS</u> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>CHRONIC BRAIN SYNDROME 20</u> <u>TO BROMIDES AND ALCOHOL (1956)</u> (B) DUE TO, OR AS A CONSEQUENCE OF: <u>CHRONIC NEPHRITIS</u> (C) <u>FRACTURE (RT.) FEMUR</u>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>6/26/70</u>			
MEDICAL CERTIFICATION											
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).											
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)							
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?							
22. I certify that (1) this hospital attended the deceased from <u>4-5-72</u> to <u>4/7/72</u> that (1) we last saw the deceased alive on <u>4-5-72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (1) We (did) (did not) view the body after death.											
23A. SIGNATURE <u>Richard F. Tyson, M.D.</u>				23B. DATE SIGNED <u>4-7-72</u>				23C. PHYSICIAN'S NAME (Type) <u>RICHARD F. TYSON, M.D.</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Cremation</u>				24B. DATE <u>4/13/72</u>				24C. NAME OF CEMETERY or CREMATORY <u>Fort Lincoln Cemetery</u>			
24D. LOCATION (City, town, or county) (State) <u>BALTO 21217 Md.</u>				25A. DATE REC'D BY HEALTH DEPT. <u>APR 21 1972</u>				25B. NAME OF REGISTRAR <u>Robert E. Taylor, M.D.</u>			
25C. FUNERAL DIRECTOR <u>Richard F. Tyson, M.D.</u>				25D. ADDRESS <u>Richard F. Tyson, M.D.</u>							



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

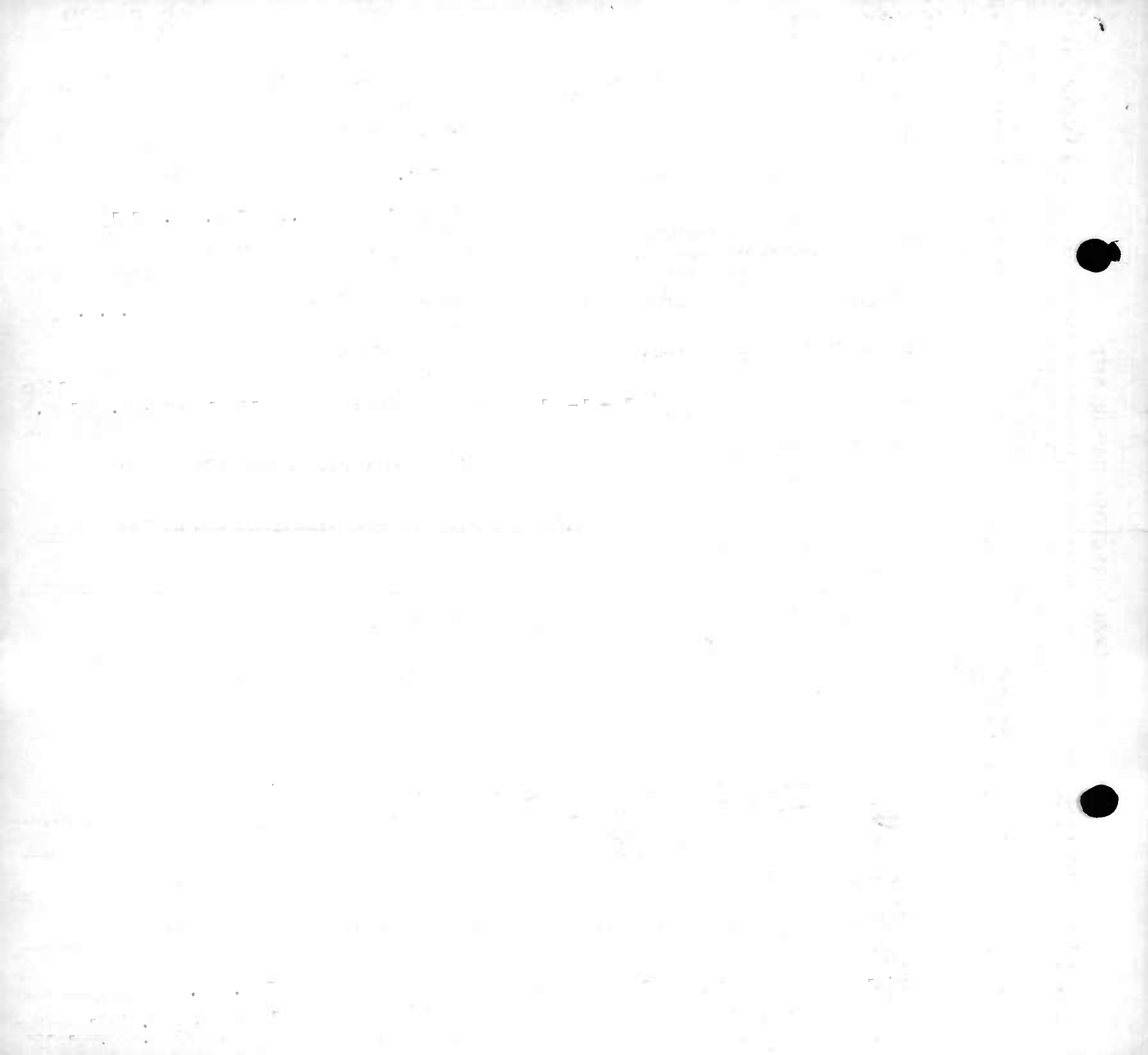
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 03831	
BIRTH NO. 1-525 72 03831		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <u>Demetrie Johnson</u>		2. DATE AND HOUR OF DEATH <u>4-15-72</u> <u>14</u> <u>10</u> P. M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institutions: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>90 MIDTOWN NURSING HOME</u> <u>808 ST. PAUL STREET</u>		A. STATE <u>Maryland</u>		B. COUNTY <u>1205</u>	
		C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER <u>1730 ST. PAUL ST.</u>			
5. SEX <u>F</u>	6. RACE <u>Cauc.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5-28-13</u>	9. AGE (In years last birthday) <u>58</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homemaker</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Waitress</u>		11. BIRTHPLACE (State or foreign country) <u>ILLINOIS</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		13. FATHER'S NAME <u>Henry Demos</u>		14. MOTHER'S MAIDEN NAME <u>Sophie Demos</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>unk.</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>GREEK Church Md. AVE. & PRESTON ST.</u>	
18. <u>180X I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH <u>Cardio Respiratory Failure</u> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Carotid artery of Cervical with Generalized atherosclerosis - brain etc</u> (B) DUE TO, OR AS A CONSEQUENCE OF: <u>metastasis - brain etc</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2</u> <u>2</u> <u>?</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>no</u>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>4-10-72</u> 19 <u>72</u> to <u>4-15</u> 19 <u>72</u> that (I) (we) last saw the deceased alive on <u>4-14</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>William Applefeld</u>		Abiding Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <u>4-15-72</u>	
23C. PHYSICIAN'S NAME (Type) <u>William Applefeld</u>		23D. ADDRESS <u>6615 Reisterstown Rd</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>4-17-72</u>		24C. NAME of CEMETERY or CREMATORY <u>GREEK ORTHODOX CEMETERY</u>	
24D. LOCATION (City, town, or county) (State) <u>BALTO., MARYLAND</u>					
25A. DATE REC'D BY HEALTH DEPT. <u>APR 21 1972</u>		25B. NAME OF REGISTRAR <u>John E. Taylor, Jr.</u>		25C. FUNERAL DIRECTOR <u>MATTHEWS FUNERAL HOME</u>	
				ADDRESS <u>3021 EASTERN AVE</u>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 03832	
<div style="display: flex; justify-content: space-between;"> P-120 72 03832 CERTIFICATE OF DEATH </div>					
1. NAME OF DECEASED (Type or Print) PIVEC, JOHN FRANK			2. DATE AND HOUR OF DEATH 4/17/72 11250 A M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION JOHNS HOPKINS HOSPITAL 33			A. STATE MARYLAND B. COUNTY 2643 C. CITY OR TOWN BALTO. D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 3504 Elmora Ave., Balto. Md. 21213		
5. SEX M	6. RACE CAUCASIAN	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/30/84	9. AGE (In years last birthday) 87	If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) TRAILOR		10B. KIND OF BUSINESS OR INDUSTRY CARMENTS	11. BIRTHPLACE (State or foreign country) BALTIMORE		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME UNKNOWN Frank Pivec			14. MOTHER'S MAIDEN NAME UNKNOWN		
15. Was Deceased Ever In U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 215-01-8710	17. INFORMANT ADDRESS Joseph Pivec (son) 5811 Plumer Ave. Balto. 21206		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 410.9 I MYOCARDIAL INFARCTION DAYS			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE YEARS			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C)		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). AGGRAVATION PNEUMONITIS					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) YES	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED White At <input type="checkbox"/> Not White At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) <u>(this hospital)</u> attended the deceased from <u>April 4</u> 19 <u>72</u> to <u>April 17</u> 19 <u>72</u> that (I) <u>(we)</u> last saw the deceased alive on <u>April 17</u> 19 <u>72</u> and that (in my) <u>(our)</u> opinion death occurred on the date and hour and from the causes stated above. (I) <u>(We)</u> <u>(did)</u> view the body after death.					
23A. SIGNATURE Robert C. Bost, Jr.				23B. DATE SIGNED 4/17/72	
23C. PHYSICIAN'S NAME (Type) ROBERT C. BOST, JR. MD				23D. ADDRESS JOHNS HOPKINS HOSPITAL	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4/20/72		24C. NAME OF CEMETERY or CREMATORY Holy Redeemer Cemetery	
24D. LOCATION (City, town, or county) (State) Balto. Md.		25A. DATE REC'D BY HEALTH DEPT. APR 21 1972			
25B. NAME OF REGISTRAR John C. Taylor, Jr.		25C. FUNERAL DIRECTOR Schimunek Funeral Homes, Inc.		ADDRESS 3331 Brehms Lane, Balto. Md. 21213	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1. NAME OF DECEASED (Type or Print) FOX, Augustus ALD yins		2. DATE AND HOUR OF DEATH 4/18/72 5:30 P M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) THE JOHNS HOPKINS HOSPITAL 33		4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 1801 N. Duncan St.	
5. SEX M	6. RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 4/9/04
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) unknown		10B. KIND OF BUSINESS OR INDUSTRY unknown	11. BIRTHPLACE (State or foreign country) unknown
13. FATHER'S NAME Joseph FOX		14. MOTHER'S MAIDEN NAME Lena Hickland	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) unknown		16. SOCIAL SECURITY NO. unknown	17. INFORMANT Joseph FOX ADDRESS 1801 N. Duncan St.
18. CAUSE OF DEATH I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Cerebrovascular Accident ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). 19A. DATE OF OPERATION 0 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED No 20A. AUTOPSY (Yes or No) No 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? No			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 36 hr
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) No	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) No		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR No		21G. WHERE DID INJURY OCCUR (If in Baltimore City, give exact location) No	
22. I certify that (I) (this hospital) attended the deceased from 4/17 19 72 to 4/18/72 19 72 and that (I) (we) last saw the deceased alive on 4/18 19 72 and that (I) (my) (our) opinion of death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE Malcolm Herring		23B. DATE SIGNED 4/18/72	
23C. PHYSICIAN'S NAME (Type) Malcolm Herring, M.D.		23D. ADDRESS Johns Hopkins Hospital	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 4/24/72	24C. NAME OF CEMETERY or CREMATORY St. Luke's Cemetery	24D. LOCATION (City, town, or county) (State) Baltimore, Md.
25A. DATE REC'D BY HEALTH DEPT. APR 21 1972	25B. NAME OF REGISTRAR Johns Hopkins	25C. FUNERAL DIRECTOR Johns Hopkins	ADDRESS Johns Hopkins

2501

2510

2520



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

F-260 72 03834				BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 03834	
BIRTH NO.				1. NAME OF DECEASED (Type or Print)			
				William Fischer			
2. DATE AND HOUR OF DEATH				4/16/72 3:15 P. M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				A. STATE B. COUNTY			
00 2427 E. Madison St.				Md. 702			
5. SEX				6. RACE			
M W				W			
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>				8. DATE OF BIRTH			
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9/16/95			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY			
registered nurse				Lexington Bros. Hosp. New York			
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
William Fischer				Mary Fischenbach			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
yes WW I				135-14-7485			
17. INFORMANT				ADDRESS			
Lula Fisher (wife)				same as above			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				CAUSE OF DEATH			
412.4 + 011.9				Massive Pulmonary Edema			
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
ANTECEDENT CAUSES				Chronic C. & T. disease			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) DUE TO, OR AS A CONSEQUENCE OF:			
II				Pulmonary T.B.			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
19A. DATE OF OPERATION				1 day			
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED				20A. AUTOPSY? (Yes or No)			
0				20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				21D. TIME OF INJURY (Month) (Day) (Year) (Hour)			
21E. INJURY OCCURRED				21F. HOW DID INJURY OCCUR?			
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				22. I certify that (I) (this hospital) attended the deceased from 4/16/72 to 4/16/72			
23A. SIGNATURE				23B. DATE SIGNED			
Louis F. Klimes M.D.				4/17/72			
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
Dr. Louis F. Klimes				2623 E. Monument St.			
24A. BURIAL CREMATION REMOVAL (Specify)				24B. DATE			
Burial				4/19/72			
24C. NAME OF CEMETERY OR CREMATORY				24D. LOCATION (City, town, or county) (State)			
Meadowridge Mem. Pk. Cem.				Balto. Md.			
25A. DATE REC'D BY HEALTH DEPT.				25B. NAME OF REGISTRAR			
APR 21 1972				John E. Taylor M.D.			
25C. FUNERAL DIRECTOR				ADDRESS			
Schimunek Funeral Homes, Inc.				3331 Brehms Lane, Balto. Md. 21213			

John C. Johnson
John C. Johnson
John C. Johnson

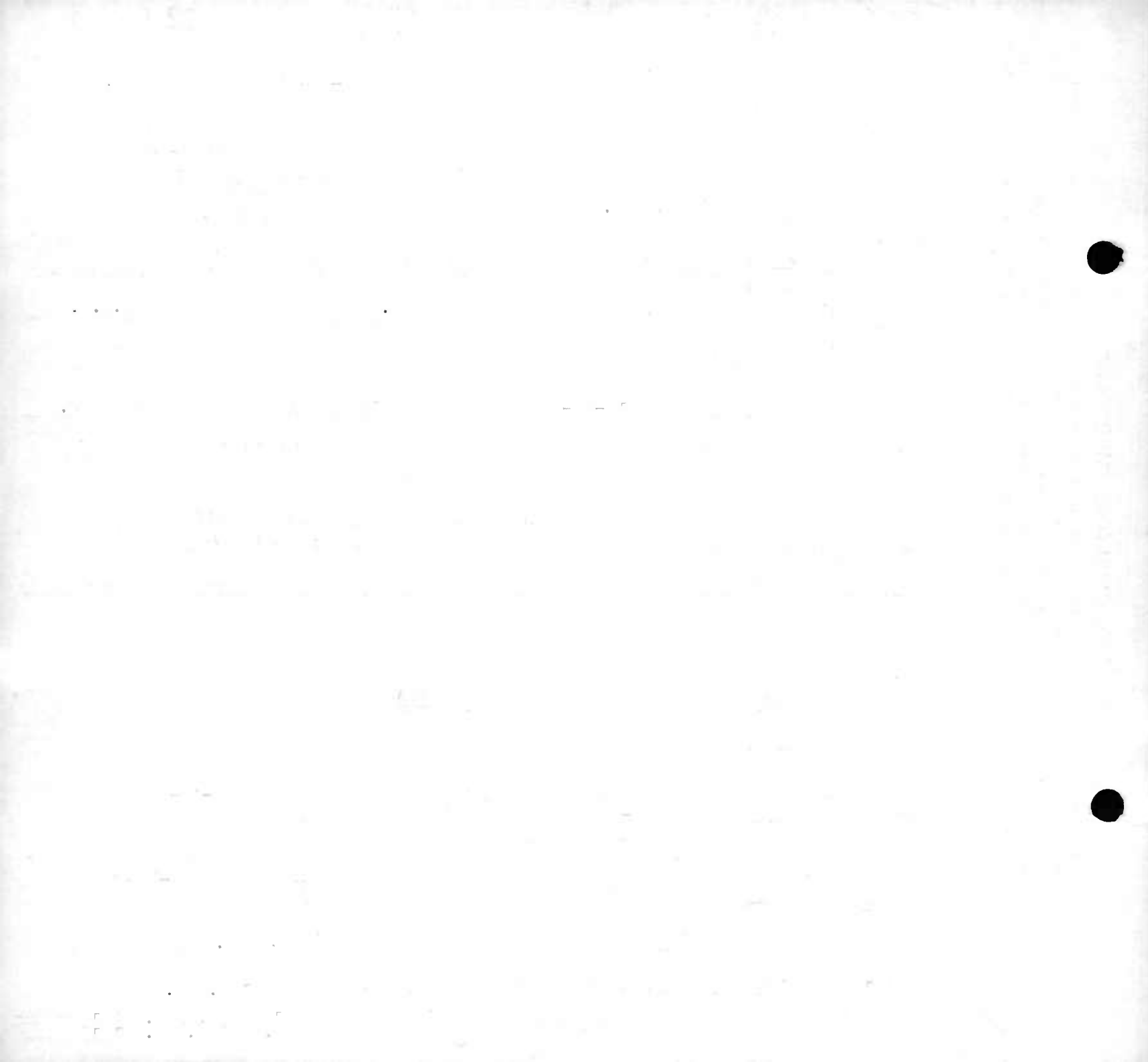
John C. Johnson
John C. Johnson

John C. Johnson
John C. Johnson

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

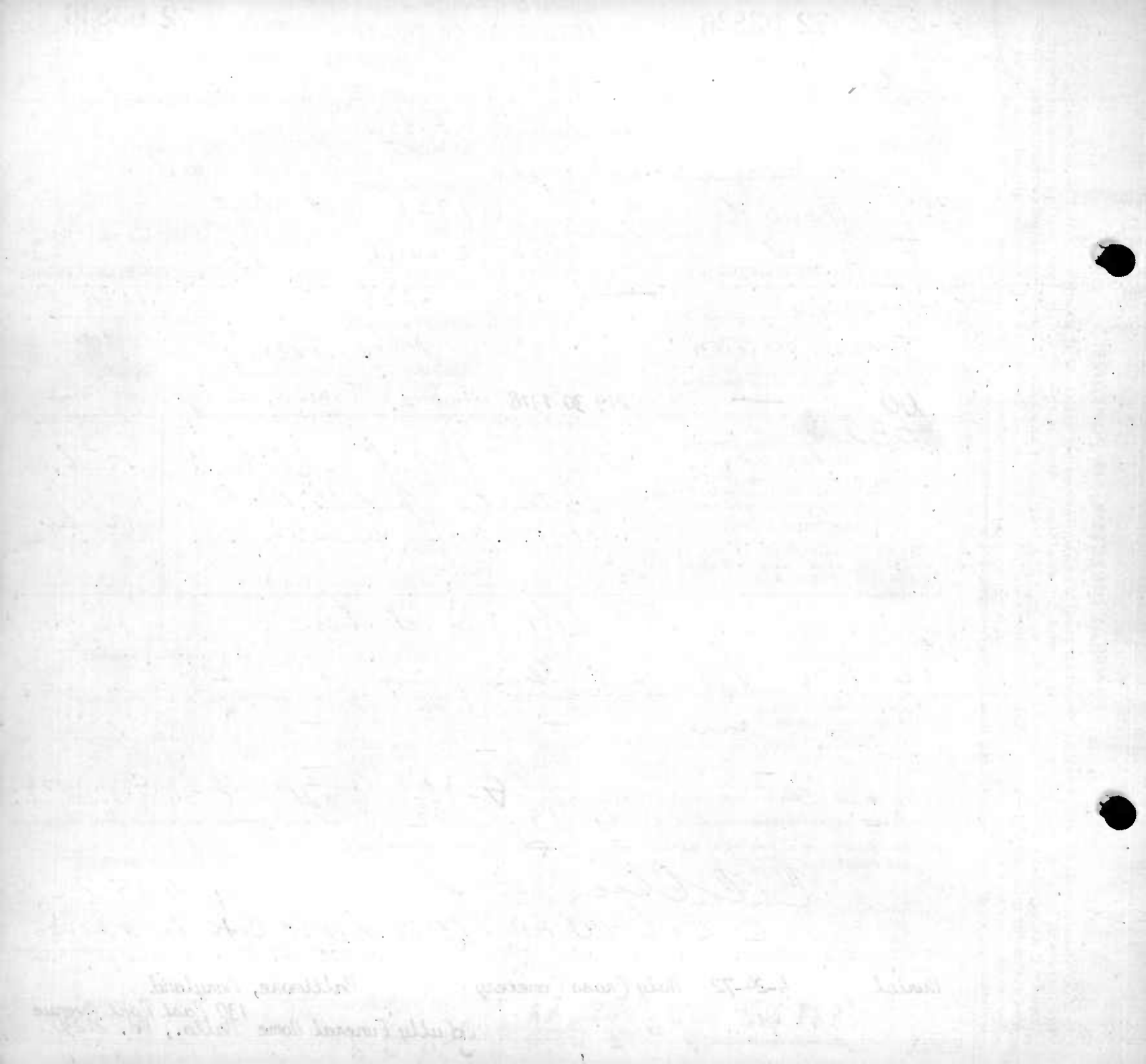
BALTIMORE CITY HEALTH DEPARTMENT				72 03835	
F-326 72 03835				CERTIFICATE OF DEATH	
BIRTH NO.				72 03835	
1. NAME OF DECEASED (Type or Print)			2. DATE AND HOUR OF DEATH		
Margaret Fitzgerald			4-16-72 8:27 P. M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION 37 Mercy Hospital, Inc.			A. STATE Md.		
			B. COUNTY 2633		
IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION			C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER 3036 Mayfield Ave		
5. SEX F	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-28-10	9. AGE (In years last birthday) 61	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10B. KIND OF BUSINESS OR INDUSTRY at home	11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Peter Knorr			14. MOTHER'S MAIDEN NAME Anna Brandt		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no			16. SOCIAL SECURITY NO. 274-30-7479		
			17. INFORMANT ADDRESS John Lewald (dghtr) 4705 Crosswood Ave.		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) MASSIVE LIVER metastases			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH months		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: CARCINOMA of colon with year		
			(B) DUE TO, OR AS A CONSEQUENCE OF: Regional extension		
			(C)		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 3-4-72		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Ca. colon		20A. AUTOPSY? (Yes or No) Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (H) (this hospital) attended the deceased from 2-21-72 to 4-16-72 that (H) (we) last saw the deceased alive on 4-16-72 and that (H) (my) (our) apintan death occurred on the date and hour and from the causes stated above. (H) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Robert G. Lancaster				23B. DATE SIGNED 4-17-72	
23C. PHYSICIAN'S NAME (Type) Robert G. Lancaster				23D. ADDRESS Mercy Hospital, Inc.	
24A. BURIAL CREMATION, 24B. DATE REMOVAL (Specify) Burial 4/20/72		24C. NAME of CEMETERY or CREMATORY Sacred Heart of Jesus Cemetery		24D. LOCATION (City, town, or county) (State) Balto. Md.	
25A. DATE REC'D BY HEALTH DEPT. APR 21 1972		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR ADDRESS Schimunek Funeral Homes, Inc. 3331 Brehms Lane, Balto. Md. 21213	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

F-250 72 03836		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 03836	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>C. Lillian Egan</i>		2. DATE AND HOUR OF DEATH <i>4-19-1972 5:37 P.</i>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <i>3 South Baltimore General Hospital 3001 S. Hanover St.</i>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Md.</i> B. COUNTY <i>2404</i> C. CITY OR TOWN <i>Baltimore</i> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <i>1726 Belt Street</i>		
5. SEX <i>F</i>	6. RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>2-20-16</i>	9. AGE (In years last birthday) <i>56</i>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10B. KIND OF BUSINESS OR INDUSTRY —		11. BIRTHPLACE (State or foreign country) <i>Md.</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		13. FATHER'S NAME <i>Joseph Grieten</i>		14. MOTHER'S MAIDEN NAME <i>Mary Feeney</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>NO</i>		16. SOCIAL SECURITY NO. <i>219 30 1318</i>		17. INFORMANT <i>Husband: Francis L. Egan</i>	
18. <i>552X1</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE <i>Partial small bowel obstruction, probably due to mesenteric embolism</i> DUE TO, OR AS A CONSEQUENCE OF: (B) <i>mesenteric embolism</i> DUE TO, OR AS A CONSEQUENCE OF: (C) —		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>12 hrs.</i> <i>12 hrs.</i> <i>10+ yrs.</i>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <i>Left inguinal hernia</i>					
19A. DATE OF OPERATION <i>14-7-72</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Left inguinal hernia</i>		20A. AUTOPSY? (Yes or No) <i>no</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <i>no</i>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) —		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) —	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) —		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? —	
22. I certify that (I) (this hospital) attended the deceased from <i>6-15-71</i> to <i>4-19-72</i> , that (I) we last saw the deceased alive on <i>4-19-1972</i> and that in (my) our opinion death occurred on the date and hour and from the causes stated above. (I) We (did) (did not) view the body after death.					
23A. SIGNATURE <i>C. C. Chiu</i>				23B. DATE SIGNED <i>4-19-72</i>	
23C. PHYSICIAN'S NAME (Type) <i>C. C. CHIU M.D.</i>		23D. ADDRESS <i>1 E. Randall St. Baltimore Md. 21230</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>4-24-72</i>		24C. NAME OF CEMETERY or CREMATORY <i>Holy Cross Cemetery</i>	
24D. LOCATION (City, town, or county) (State) <i>Baltimore, Maryland</i>		25A. DATE RECEIVED BY HEALTH DEPARTMENT <i>APR 21 1972</i>			
25B. NAME OF REGISTRAR <i>Valerie E. Kelly</i>		25C. FUNERAL DIRECTOR <i>McGully Funeral Home</i>			
25D. ADDRESS <i>130 East Fort Avenue Balto., Md. 21230</i>					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>72 03837</u>	
BIRTH NO. <u>D-400 72 03837</u>				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <u>Dorothy M. Deal</u>			2. DATE AND HOUR OF DEATH <u>4/18/1972</u>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <u>5206 Beaufort Avenue Baltimore, Maryland 21215</u>			A. STATE <u>Maryland</u> B. COUNTY <u>2788</u>		
C. CITY OR TOWN <u>Baltimore</u>			D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		
E. STREET AND NUMBER <u>5206 Beaufort Avenue 21215</u>					
5. SEX <u>Female</u>	6. RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 19, 1906</u>	9. AGE (In years last birthday) <u>65</u>	10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			11. BIRTHPLACE (State or foreign country) <u>Taylorsville, N. C.</u>		
12. CITIZEN OF WHAT COUNTRY?					
13. FATHER'S NAME <u>Charles Herman</u>			14. MOTHER'S MAIDEN NAME <u>Birlie (Barnes)</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No None</u>			16. SOCIAL SECURITY NO. <u>231-26-9946 A</u>		
17. INFORMANT <u>Baltimore, Maryland</u> <u>Mr. Trantum S. Deal 5206 Beaufort Ave.</u>			ADDRESS <u>21215</u>		
18. <u>144X I</u> CAUSE OF DEATH			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Rehabilitation, Anemia</u>			<u>3 wks</u>		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Carcinoma of Floor of Mouth</u>			<u>1 yr.</u>		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from <u>Jan 1972</u> to <u>April 1972</u> that (I) (we) last saw the deceased alive on <u>4/15 1972</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Louis Goodman</u>			23B. DATE SIGNED <u>4/19/72</u>		
23C. PHYSICIAN'S NAME (Type) <u>Robert Louis Goodman</u>			23D. ADDRESS <u>Medical Arts Building</u>		
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>4/22/1972</u>	24C. NAME of CEMETERY or CREMATORY <u>Mount Olive Cemetery</u>		24D. LOCATION (City, town, or county) (State) <u>Taylorsville Alexander Co., N. C.</u>
25A. DATE REC'D BY HEALTH DEPT. <u>APR 21 1972</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor, M.D.</u>		25C. FUNERAL DIRECTOR <u>Loring Byers Funeral Directors, P. A.</u>	

Dorothy



P-400 72 03838

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

REG. NO.

72-3838

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

RAILEY, MARJORIE E

2. DATE AND HOUR OF DEATH

April 18, 1972 1:00 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)BALTIMORE CITY HOSP, BALTIMORE
4940 Eastern Avenue Md 21224

4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)

A. STATE

B. COUNTY

Maryland

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒NO ☐

E. STREET AND NUMBER

1400 W. Lafayette Ave

21217

5. SEX

Female

6. RACE

Negro A

7. MARRIED ☐NEVER MARRIED ☐WIDOWED ☒DIVORCED ☐

8. DATE OF BIRTH

9/13/18

9. AGE (In years
last birthday)

53

If Under 1 Yr.

Months Days

If Under 24 Hrs.

Hours Min.

10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

Unemployed

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

ELMAR HAWKINS

14. MOTHER'S MAIDEN NAME

MARY MERCER

15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)

NO

16. SOCIAL
SECURITY NO.

213-12-3627

17. INFORMANT

4940 Eastern Avenue ADDRESS

BCH: RECORDS Baltimore, Maryland

21224

18. 412.3 I

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, ashenia, etc. It means the disease,
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.

CAUSE OF DEATH

CARDIOPULMONARY ARREST

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

CEREBROVASCULAR ACCIDENT

(B)

DUE TO, OR AS A CONSEQUENCE OF:

Old MYOCARDIAL INFARCTION

(C)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

10 yrs

10 yrs

10 yrs

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART 1 (A).

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

NO

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING ☐
OR CONTRIBUTING ☐ CAUSE OF
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At
Work ☐Not While
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from Jan 28 1972 to April 18 1972
that (I) (we) last saw the deceased alive on April 18 1972 and that (in my) (our) opinion death occurred on the date
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Surat S. Sinasa, M.D.

DEGREE

Attending
Phys. ☐Med.
Director ☐Staff
Phys. ☒

23B. DATE SIGNED

April 18, 1972

23C. PHYSICIAN'S
NAME (Type)

SURAT SINASA

23D. ADDRESS

4940 Eastern Avenue
BALTIMORE CITY Hosp Baltimore, Md

21224

24A. BURIAL CREMATION,
REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION

(City, town, or county)

(State)

25A. DATE REC'D BY HEALTH DEPT.

APR 21 1972

25B. NAME OF REGISTRAR

Robert E. Taylor, Jr.

25C. FUNERAL DIRECTOR

1922 Elmdale Ave

ADDRESS

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-640 12 03839

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

72 03839
REG. NO. _____

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>LOTIE M. BURREL</u>		2. DATE AND HOUR OF DEATH <u>2/20/72 3:45 PM</u>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <u>MARYLAND GENERAL HOSPITAL</u> FULL NAME OF HOSPITAL OR INSTITUTION <u>48</u>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>BALTO - BALTO Hill Nursing Home</u> B. COUNTY <u>BALTO CITY</u>		C. CITY OR TOWN <u>BALTO CITY</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <u>F</u>		6. RACE <u>N</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <u>07-22-83</u>		9. AGE (In years last birthday) <u>88</u>		10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>UNKNOWN</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>BALTO.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>216076221</u>		17. INFORMANT <u>LILLIAN NEAL</u> ADDRESS <u>4702 GREENSPRING</u>	
18. <u>4/12-3 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) <u>RESPIRATORY FAILURE</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>CONGESTIVE HEART FAILURE</u> <u>ASCVD</u>		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) <u>CONGESTIVE HEART FAILURE</u> DUE TO, OR AS A CONSEQUENCE OF: (C) <u>ASCVD</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>15 DAYS</u> <u>UNKNOWN</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>Chronic Renal Failure</u>					
19A. DATE OF OPERATION <u>D</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>02/12/72</u> 19 to <u>02/20/72</u> 19 that (I) (we) last saw the deceased alive on <u>02/20/72</u> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) <u>did</u> (did not) view the body after death.					
23A. SIGNATURE <u>George C. Sommers MD</u>				23B. DATE SIGNED <u>2/20/72</u>	
23C. PHYSICIAN'S NAME (Type) <u>George C. Sommers MD</u>				23D. ADDRESS <u>MATL</u>	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <u>3-2-72</u>		24C. NAME of CEMETERY or CREMATORY <u>Mt. Calvary Cem</u>	
24D. LOCATION <u>Cedar Hill Balto. Md.</u>		24E. CITY, town, or county		24F. STATE	
25A. DATE REC'D BY HEALTH DEPT. <u>APR 21 1972</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor</u>		25C. FUNERAL DIRECTOR <u>310. 1972</u>	

2100 Mount Royal Terrace

Adm. 11/6/69. J

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT										
CERTIFICATE OF DEATH										
REG. NO. 72 03840										
1. NAME OF DECEASED (Type or Print) <i>Nunnally, Mary F.</i>					2. DATE AND HOUR OF DEATH <i>4/20/72 7:25 A.M.</i>					
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD					4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>802</i>					
FULL NAME OF HOSPITAL OR INSTITUTION <i>33 The Johns Hopkins Hospital</i>					C. CITY OR TOWN <i>Baltimore</i>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
					E. STREET AND NUMBER <i>1718 N. Montford Avenue</i>					
5. SEX <i>Female</i>	6. RACE <i>Negro</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>11/14/16</i>	9. AGE (In years last birthday) <i>55</i>	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Va.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		
13. FATHER'S NAME <i>Harvey Corbitt</i>					14. MOTHER'S MAIDEN NAME <i>Sadie Marshall</i>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>				16. SOCIAL SECURITY NO.		17. INFORMANT <i>Carl Nunnally 178 N. Montford Ave.</i>				
18. <i>182.01</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <i>adenocarcinoma of endometrium with metastasis</i>				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>with metastasis</i>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>2 yrs 10 mos</i>		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) DUE TO, OR AS A CONSEQUENCE OF:						
(C) _____										
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).										
19A. DATE OF OPERATION <i>0 -</i>			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			20A. AUTOPSY? (Yes or No) <i>No</i>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?				
22. I certify that (I) (this hospital) attended the deceased from <i>4:18</i> 19 <i>72</i> to <i>4:20</i> 19 <i>72</i> that (I) (we) last saw the deceased alive on <i>4:19</i> 19 <i>72</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.										
23A. SIGNATURE <i>Joan Sulewski MD</i>						23B. DATE SIGNED <i>4-20-72</i>				
23C. PHYSICIAN'S NAME (Type) <i>Joan Sulewski, MD.</i>						23D. ADDRESS <i>The Johns Hopkins Hospital</i>				
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Removal</i>			24B. DATE <i>4-22-72</i>			24C. NAME OF CEMETERY or CREMATORY <i>Farmville</i>			24D. LOCATION (City, town, or county) (State) <i>Va.</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>APR 21 1972</i>			25B. NAME OF REGISTRAR <i>Robert E. Taylor, Jr.</i>			25C. FUNERAL DIRECTOR <i>Midland-Khick's</i>			ADDRESS <i>12 M. Court</i>	



B-426
72 03841 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 72 03841

BIRTH NO.

1. NAME OF DECEASED (Type or Print) STEFANIA BALCEROWICZ		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 00 701 Van Lill		3. DATE PRONOUNCED DEAD Month Day Year Hour April 5, 1972 9:40 A.	
6. SEX Female		7. RACE White	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore	
9. DATE OF BIRTH 1892		10. AGE (In years last birthday) 80	
11. BIRTHPLACE (State or foreign country) Unknown		12. CITIZEN OF WHAT COUNTRY?	
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		14B. KIND OF BUSINESS OR INDUSTRY	
15. MOTHER'S MAIDEN NAME Unknown		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No	
17. SOCIAL SECURITY NO. 215-01-6081		18. INFORMANT Bank & Broadway, ADDRESS Balto, Md. REV. GEORGE JOSEPH PUGH, St. Patrick Church	
19. 412-41 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		CAUSE OF DEATH Arteriosclerotic cardiovascular disease (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C)	
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIB. <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?		21. AUTOPSY? (Yes or No) no	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <i>Ronald N. Kornblum</i> M.D. EXAMINER'S NAME (Type) Ronald N. Kornblum, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 4/5/72			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 20 Apr 72	
24C. NAME OF CEMETERY or CREMATORY Holy Rosary Cemetery		24D. LOCATION (City, town, or county) (State) German Hill Rd, Balto, Md	
25A. DATE REC'D BY HEALTH DEPT. APR 21 1972		25B. NAME OF REGISTRAR J. E. Taylor, Jr.	
25C. FUNERAL DIRECTOR LILLY & ZEILER INC, 1901 Eastern Ave, City		ADDRESS	

11-20-57

11-20-57

11-20-57

11-20-57

11-20-57

11-20-57

11-20-57

11-20-57

11-20-57

11-20-57

11-20-57

11-20-57

11-20-57

11-20-57

11-20-57

11-20-57

11-20-57

11-20-57

11-20-57

11-20-57

11-20-57

11-20-57

11-20-57

11-20-57

11-20-57

11-20-57

11-20-57

11-20-57

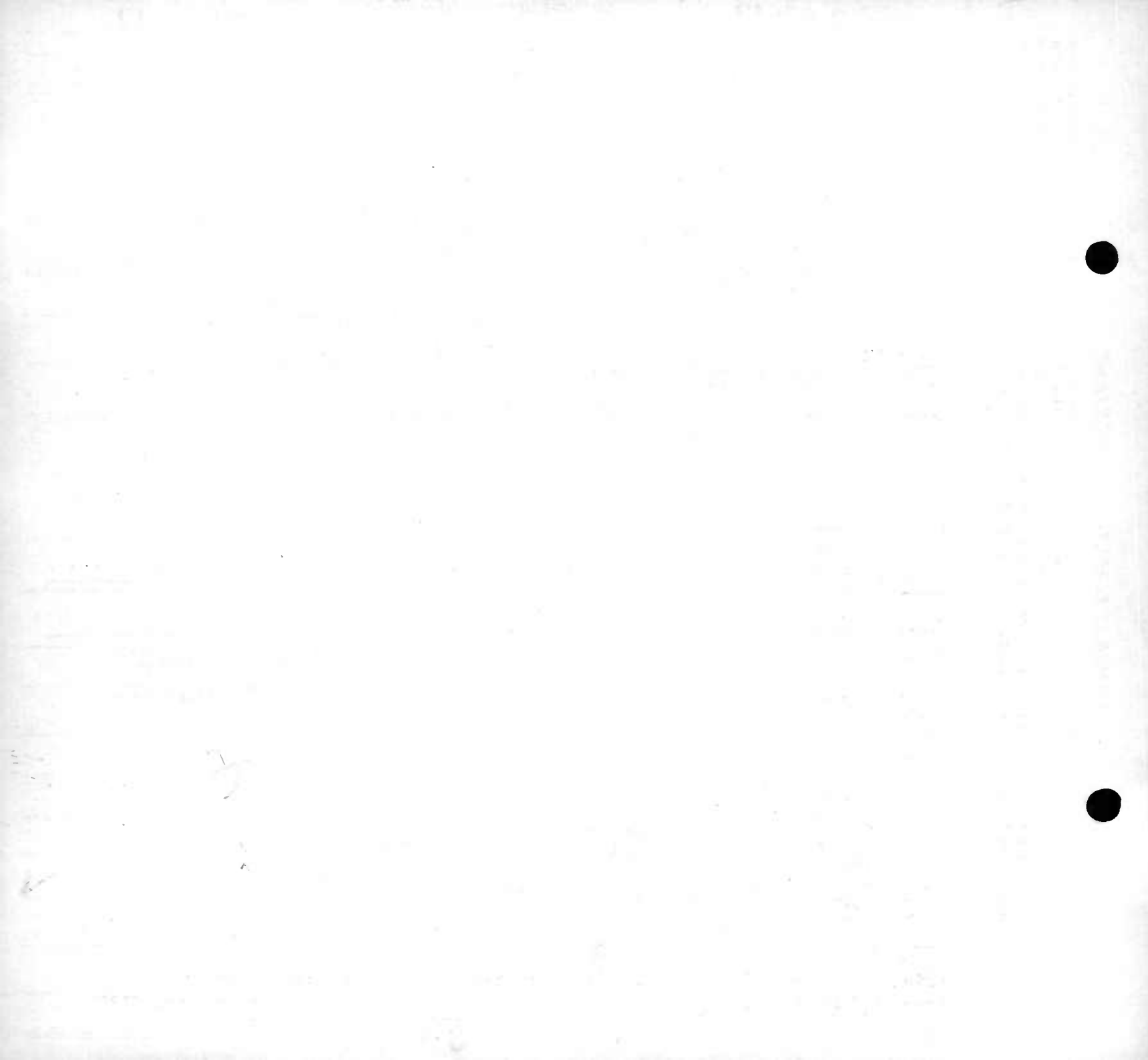
11-20-57

11-20-57

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

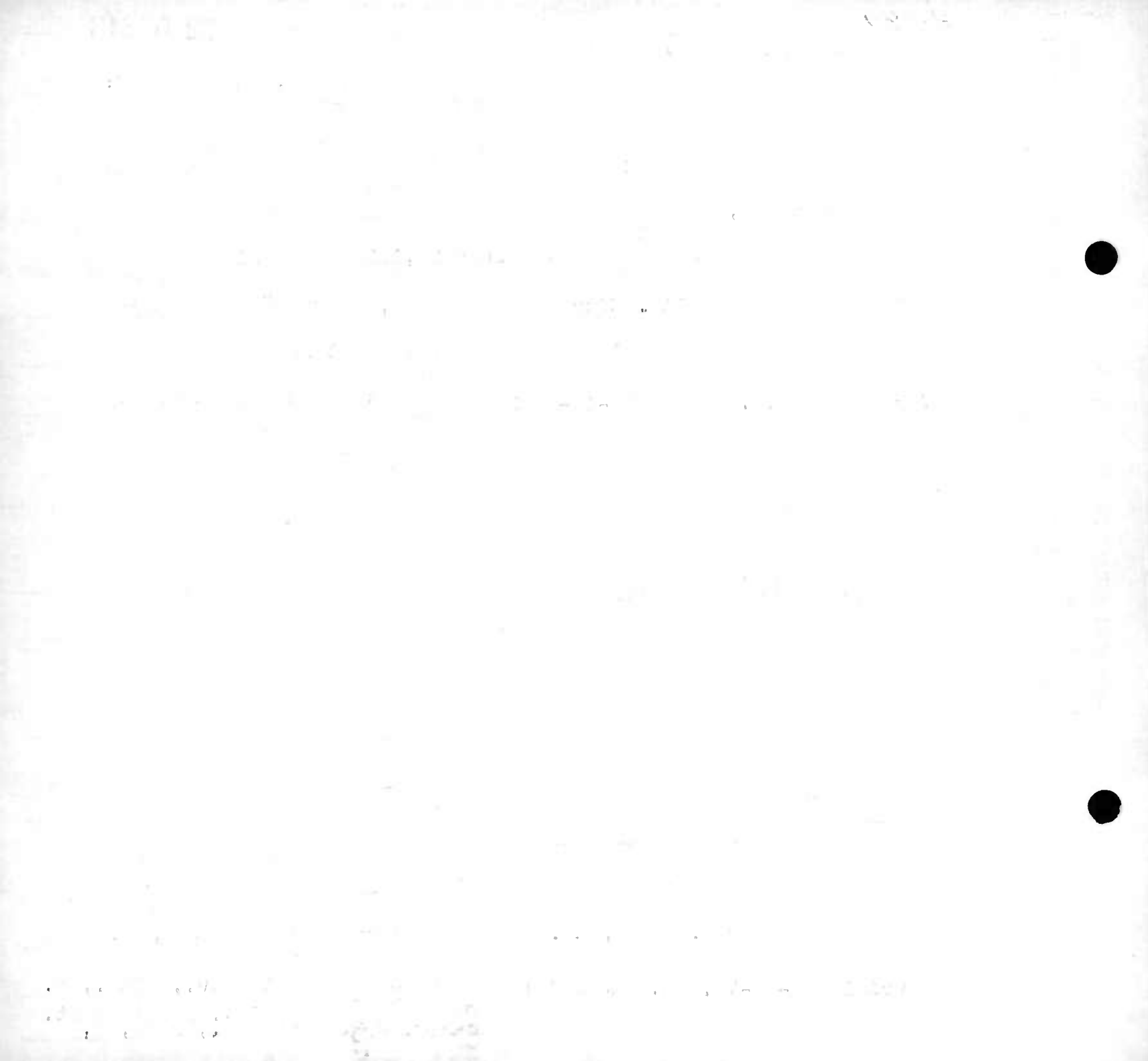
BIRTH NO.				BALTIMORE CITY HEALTH DEPARTMENT				CERTIFICATE OF DEATH				REG. NO. 72 03842			
1. NAME OF DECEASED (Type or Print) EDDIE C. BELL								2. DATE AND HOUR OF DEATH April 20 1972 2:22 AM							
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) JOHNS HOPKINS Hospital 33								4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD B. COUNTY Baltimore C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 2312 Garrett Ave							
5. SEX M		6. RACE B		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9/25/1908		9. AGE (In years last birthday) 63		If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PARKING LOT ATTEND				10B. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country) South Carolina				12. CITIZEN OF WHAT COUNTRY? US			
13. FATHER'S NAME ROBERT BELL								14. MOTHER'S MAIDEN NAME GRETCHEN Clark							
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. 237-05-2827				17. INFORMANT 2312 Garrett Ave Mrs Mary Bell ADDRESS 21218							
18. 519.3 14 250.9 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Cardiopulmonary Arrest ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last Acute Respiratory Respiratory failure Severe COPD, Viral Pneumonia								CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Cardiopulmonary Arrest (B) DUE TO, OR AS A CONSEQUENCE OF: Acute Respiratory Respiratory failure (C) Severe COPD, Viral Pneumonia				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 20 min 3 days 1-2 wks			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). Diabetes Mellitus, Digitalis Toxicity															
19A. DATE OF OPERATION 0				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED				20A. AUTOPSY? (Yes or No) No				20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)				21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)							
21D. TIME OF INJURY (APPROX.) 1 (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				21F. HOW DID INJURY OCCUR?							
22. I certify that (I) (this hospital) attended the deceased from April 17 1972 to April 20 1972 that (I) (we) last saw the deceased alive on April 20 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.															
23A. SIGNATURE R. Alan Maurer MD DEGREE								23B. DATE SIGNED April 20, 1972				23C. PHYSICIAN'S NAME (Type) R. ALAN MAURER MD DEGREE			
23D. ADDRESS 6 Johns Hopkins Hosp 201 N. Broadway MD.															
24A. BURIAL CREMATION, REMOVAL (Specify) Burial				24B. DATE 4-24-72				24C. NAME OF CEMETERY OR CREMATORY Mt. Auburn Cemetery				24D. LOCATION (City, town, or county) (State) Baltimore, Maryland			
25A. DATE REC'D BY HEALTH DEPT. APR 21 1972				25B. NAME OF REGISTRAR Robert E. Jones, Jr.				25C. FUNERAL DIRECTOR 1735 Harford Ave. 21213 Marshall W. Jones, Jr.							



FUNERAL DIRECTOR: IMPORTANT

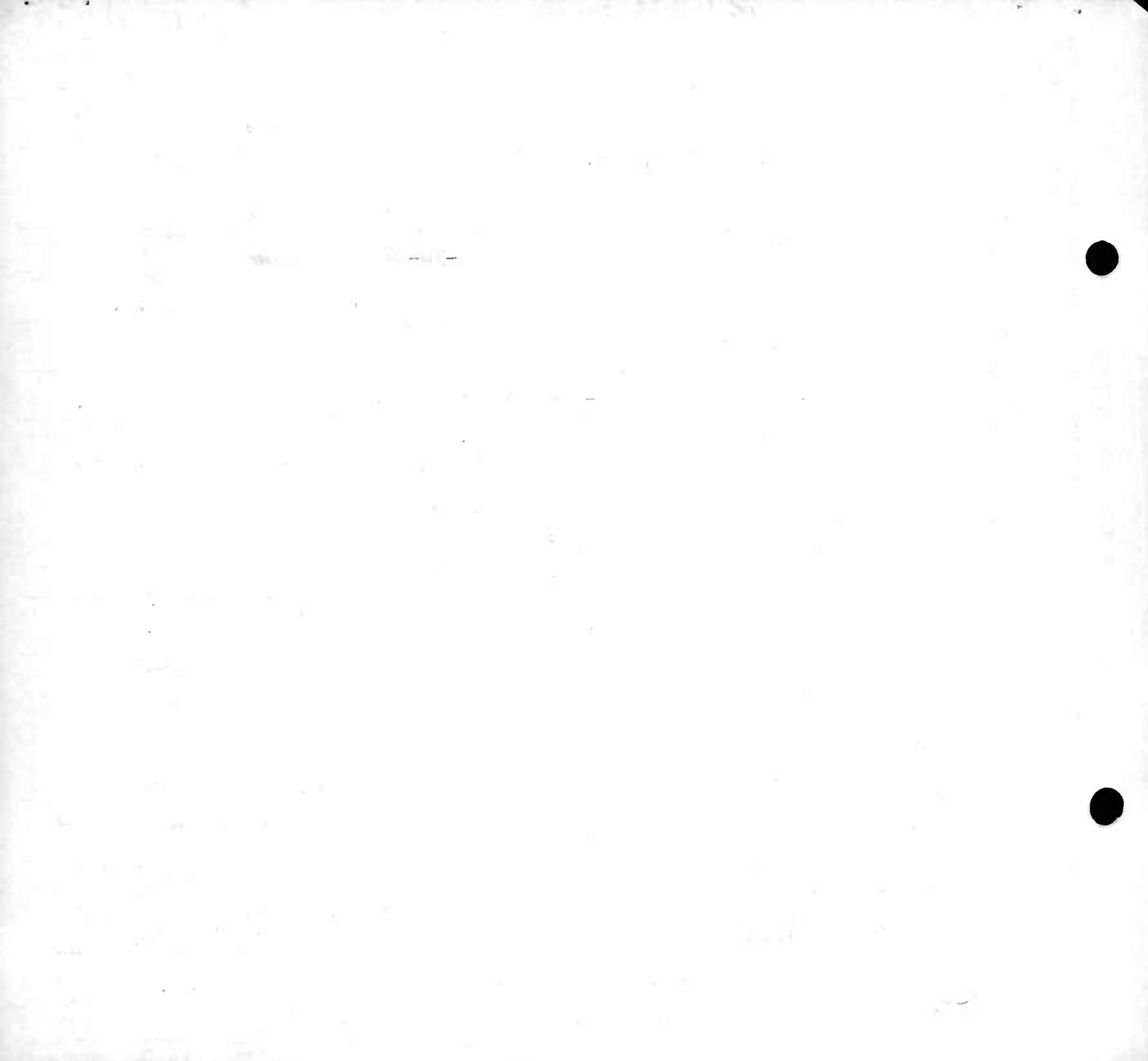
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 03843	
BIRTH NO. 72 03843		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) William Arnold Hennel		2. DATE AND HOUR OF DEATH April 19, 1972 9:42 p.m.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 31 IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland 21224		4. USUAL RESIDENCE (Where deceased lived, if institutions residence before admission) A. STATE Maryland B. COUNTY 2609 C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 3402 Mueller Street 21224			
5. SEX Male	6. RACE Caucasian	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 26, 1920	9. AGE (in years last birthday) 51	10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Watchman		10B. KIND OF BUSINESS OR INDUSTRY Balto. City		11. BIRTHPLACE (State or foreign country) Maryland, Baltimore	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Clarence Hennel		14. MOTHER'S MAIDEN NAME Jeanette Watson	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes W.W.II		16. SOCIAL SECURITY NO. 212-14-0983		17. INFORMANT ADDRESS BCH RECORDS: 4940 Eastern Avenue 21224	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). Ca. of Lung		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Respiratory Arrest		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from 4/19 1972 to 4/19 1972 that (I) (we) last saw the deceased alive on 4/19 1972 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE R. D. Kramer M.D.		23B. DATE SIGNED 4/19/72		23C. PHYSICIAN'S NAME (Type) Ronald D. Kramer, M.D.	
23D. ADDRESS 4940 Eastern Avenue, Baltimore, Md. 21224		24A. BURIAL CREMATION, REMOVAL (Specify) Burial			
24B. DATE 4-24-72		24C. NAME OF CEMETERY or CREMATORY St. Stanislaus Cemetery		24D. LOCATION (City, town, or county) (State) 6015 Boston Av., Balto., Md.	
25A. DATE REC'D BY HEALTH DEPT. APR 21 1972		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR ADDRESS 901 S. Conkling St. Balto., 21224, Md.	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

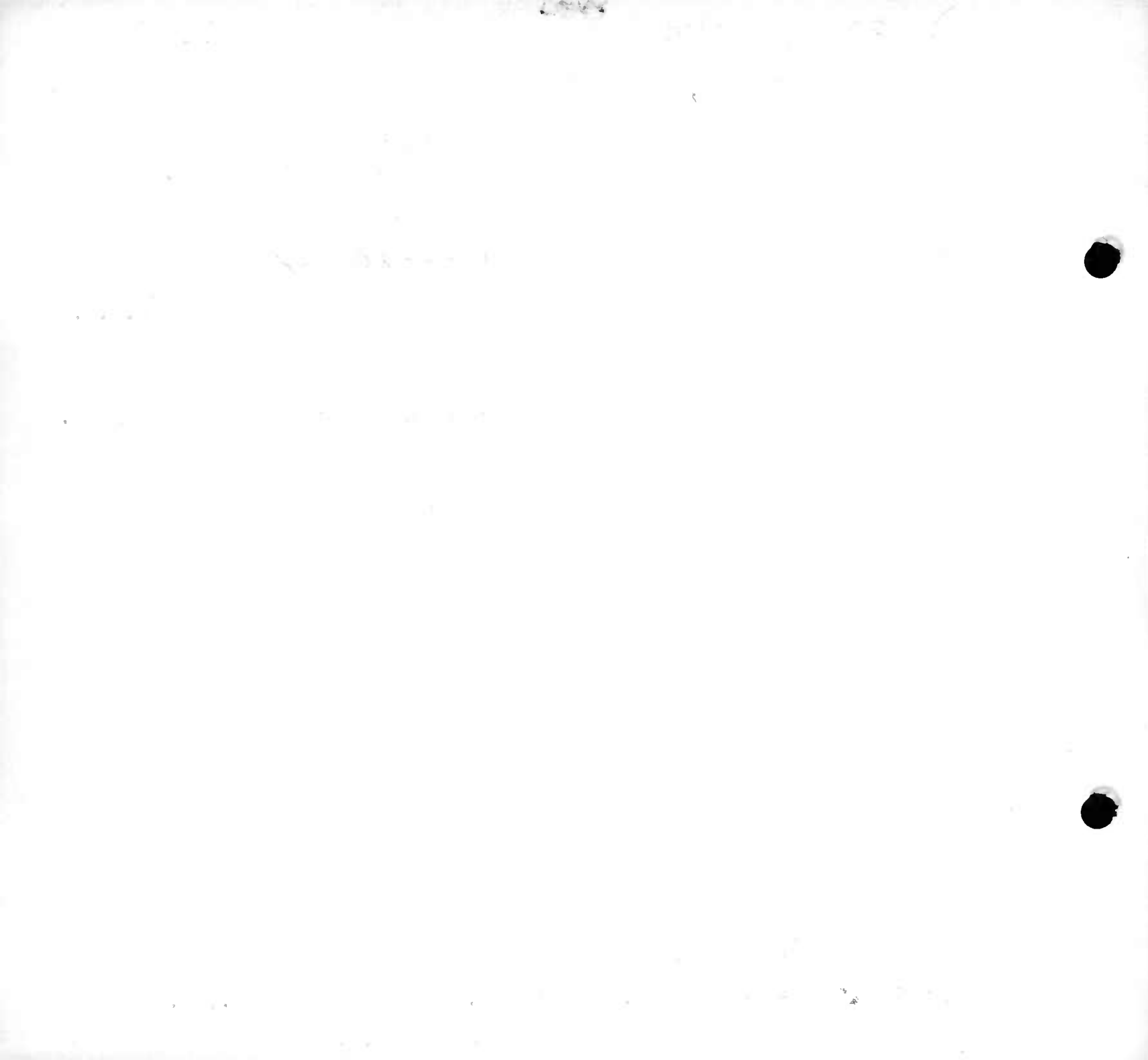
B-650 72 03814 BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 03814	
BIRTH NO.				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) BROWN, PERCY			2. DATE AND HOUR OF DEATH 19 APR 72 1 03 P.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Provident Hospital, Inc.			A. STATE 1324 Shields Place B. COUNTY 1703		
C. CITY OR TOWN Baltimore			D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
E. STREET AND NUMBER 1324 Shields Place					
5. SEX M	6. RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-30-03	9. AGE (In years last birthday) 68	10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unemployed		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME James Brown		14. MOTHER'S MAIDEN NAME Clara Henry	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Unknown		16. SOCIAL SECURITY NO. 213-20-5534		17. INFORMANT ADDRESS Hattie Ross 1526 Lanvale St.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) 250.91 MYOCARDIAL INFARCTION			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 HR.		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: ASCVD		
			(B) DUE TO, OR AS A CONSEQUENCE OF: Diabetes mellitus		
			(C) Congestive heart failure		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) <u>this hospital</u> attended the deceased from 18 Feb 1972 to 3 Feb 1972 that (1) <u>we</u> last saw the deceased alive on 3 Feb 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) <u>We</u> (did) (did not) view the body after death.					
23A. SIGNATURE Richard Lyson, MD				23B. DATE SIGNED 19 Apr 72	
23C. PHYSICIAN'S NAME (Type) RICHARD LYSON, MD.				23D. ADDRESS 936 W. NORTH Ave. BALTO 21217 Md.	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY	
Burial		4-24-72		Mt. Auburn Cem.	
24D. LOCATION (City, town, or county) (State)		25A. DATE REC'D BY HEALTH DEPT.			
Baltimore, Md.		25B. NAME OF REGISTRAR V. Bailey			
25C. FUNERAL DIRECTOR Kelson F.H.		ADDRESS 1348 Calhoun Street			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. D-120		72 03845		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 03845	
1. NAME OF DECEASED (Type or Print) DAVIS, EDWARD				2. DATE AND HOUR OF DEATH 4/19/72 9:50 A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 1602			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) LUTHERAN Hosp. of Md. Baltimore, Md. 21216				C. CITY OR TOWN Balt. Md. 21216		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER 1206 N. STRICKER ST.			
5. SEX M	6. RACE C N	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH 12-2-20	9. AGE (In years last birthday) 51	10. Under 1 Yr. Months: Days: Hours: Mins.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. 218039018		17. INFORMANT Maybelle Eads	
				ADDRESS 1206 Stricker St.			
18. 16119 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) TERMINAL CA. OF gangrene				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH WORTH			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: gangrene			
				(B) DUE TO, OR AS A CONSEQUENCE OF:			
				(C) DUE TO, OR AS A CONSEQUENCE OF:			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) 4 19 72 9:50		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 4/19/72 to 4/19/72 that (I) (we) last saw the deceased alive on 4/19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE E. N. Gayoso				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 4/19/72	
23C. PHYSICIAN'S NAME (Type) E. N. Gayoso				23D. ADDRESS Lutheran Hosp. of Md. 21216			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4-24-72		24C. NAME OF CEMETERY OR CREMATORY Mt. Auburn Cem.		24D. LOCATION (City, town, or county) (State) Balto., Md.	
25A. DATE REC'D BY HEALTH DEPT. APR 21 1972		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR V. Bailey		ADDRESS 1348 Calhoun Street	



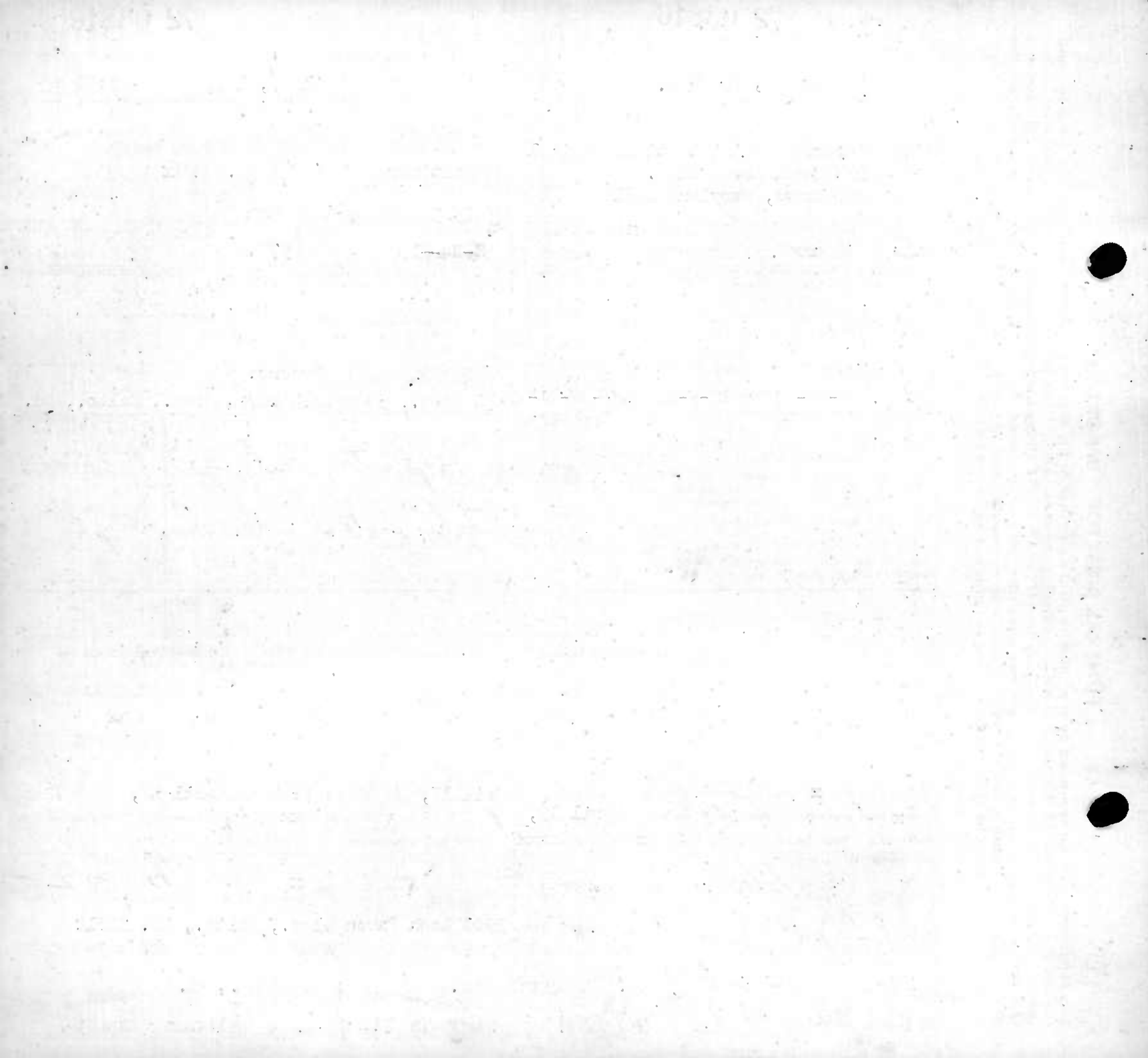
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

REG. NO. 72 03846

BIRTH NO. <u>8-542</u> 1. NAME OF DECEASED (Type or Print) <u>SMALLS, Frank B.</u>		2. DATE AND HOUR OF DEATH <u>April 19, 1972</u> <u>3:00 a</u> M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>Veterans Administration Hospital</u> <u>3900 Loch Raven Blvd.</u> <u>Baltimore, Maryland 21218</u>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>2716</u> C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>2523 Cold Spring Lane</u>	
5. SEX <u>Male</u> 6. RACE <u>Negro</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-15-15</u> 9. AGE (In years last birthday) <u>57</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>S.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) <u>Yes</u> (If yes, give war or dates of service) <u>7-30-42 to 12-9-44</u>		16. SOCIAL SECURITY NO. <u>247-07-46-49</u>	
17. INFORMANT <u>Evelyn Smalls</u> <u>Records same</u> <u>VA Hosp., 3900 Loch Raven Blvd., Balto., Md.</u>		ADDRESS	
18. <u>348.01</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>Respiratory Failure</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>Amiotrophic Lateral sclerosis</u> DUE TO, OR AS A CONSEQUENCE OF: (C)	
19. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <u>AS</u> (this hospital) attended the deceased from <u>April 17, 1972</u> to <u>April 17, 1972</u> , that <u>W</u> (we) last saw the deceased alive on <u>April 19, 1972</u> and that in <u>AS</u> (our) opinion death occurred on the date and hour and from the causes stated above. <u>(X)</u> (We) (did) <u>NOT</u> view the body after death.			
23A. SIGNATURE <u>R. W. Mellinger MD</u> 23C. PHYSICIAN'S NAME (Type) <u>Richard W. Mellinger MD</u>		23B. DATE SIGNED <u>4/20/72</u> Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>4-24-72</u>	
24C. NAME OF CEMETERY or CREMATORY <u>Mt. Auburn Cem.</u>		24D. LOCATION (City, town, or county) (State) <u>Balto., Md.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>APR 21 1972</u>		25B. NAME OF REGISTRAR <u>Robert E. Bailey, R.S.</u>	
25C. FUNERAL DIRECTOR <u>V. Bailey</u>		ADDRESS <u>1348 Calhoun Street</u>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

C-100 72 03847		BALTIMORE CITY HEALTH DEPARTMENT		72 03847	
BIRTH NO. <u>La Plata, Md.</u>		CERTIFICATE OF DEATH		REG. NO. <u>72 03847</u>	
1. NAME OF DECEASED (Type or Print) <u>B.B. Carey</u>		2. DATE AND HOUR OF DEATH <u>4/17/72</u> <u>11 45</u> A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <u>Johns Hopkins Hospital</u>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Md.</u> B. COUNTY <u>CHARLES</u>			
FULL NAME OF HOSPITAL OR INSTITUTION <u>Johns Hopkins Hospital</u>		C. CITY OR TOWN <u>Manjemo</u>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <u>M</u>		6. RACE <u>N</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		8. DATE OF BIRTH	
11. BIRTHPLACE (State or foreign country) <u>La Plata, Md.</u>		9. AGE (In years last birthday) <u>102</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>746.81</u>		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Cardiopulmonary Arrest</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>15 min</u>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) <u>Congestive Heart Failure</u> DUE TO, OR AS A CONSEQUENCE OF:		<u>10 days</u>	
		(C) <u>Congenital Heart disease</u>		<u>10 days</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>Probable Total Anomalous Pulmonary Venous Return</u>					
19A. DATE OF OPERATION <u>4/10, 4/17</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Cardiac Catheterization</u>		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>Apr 9</u> 19 <u>72</u> to <u>Apr 17</u> 19 <u>72</u> that (I) (we) last saw the deceased alive on <u>Apr 17</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Marie McCormick MD</u>		23B. DATE SIGNED <u>4/17/72</u>		23C. PHYSICIAN'S NAME (Type) <u>Marie C McCormick MD</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Cremation</u>		24B. DATE <u>4/18/72</u>		24C. NAME of CEMETERY or CREMATORY <u>Johns Hopkins Hospital</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>APR 21 1972</u>		25B. NAME OF REGISTRAR <u>Robert E. Carey, M.D.</u>		25C. FUNERAL DIRECTOR <u>3 HOSPITAL DISPOSAL</u>	
24D. LOCATION <u>601 N. Broadway Balto., MD.</u>		24E. ADDRESS			

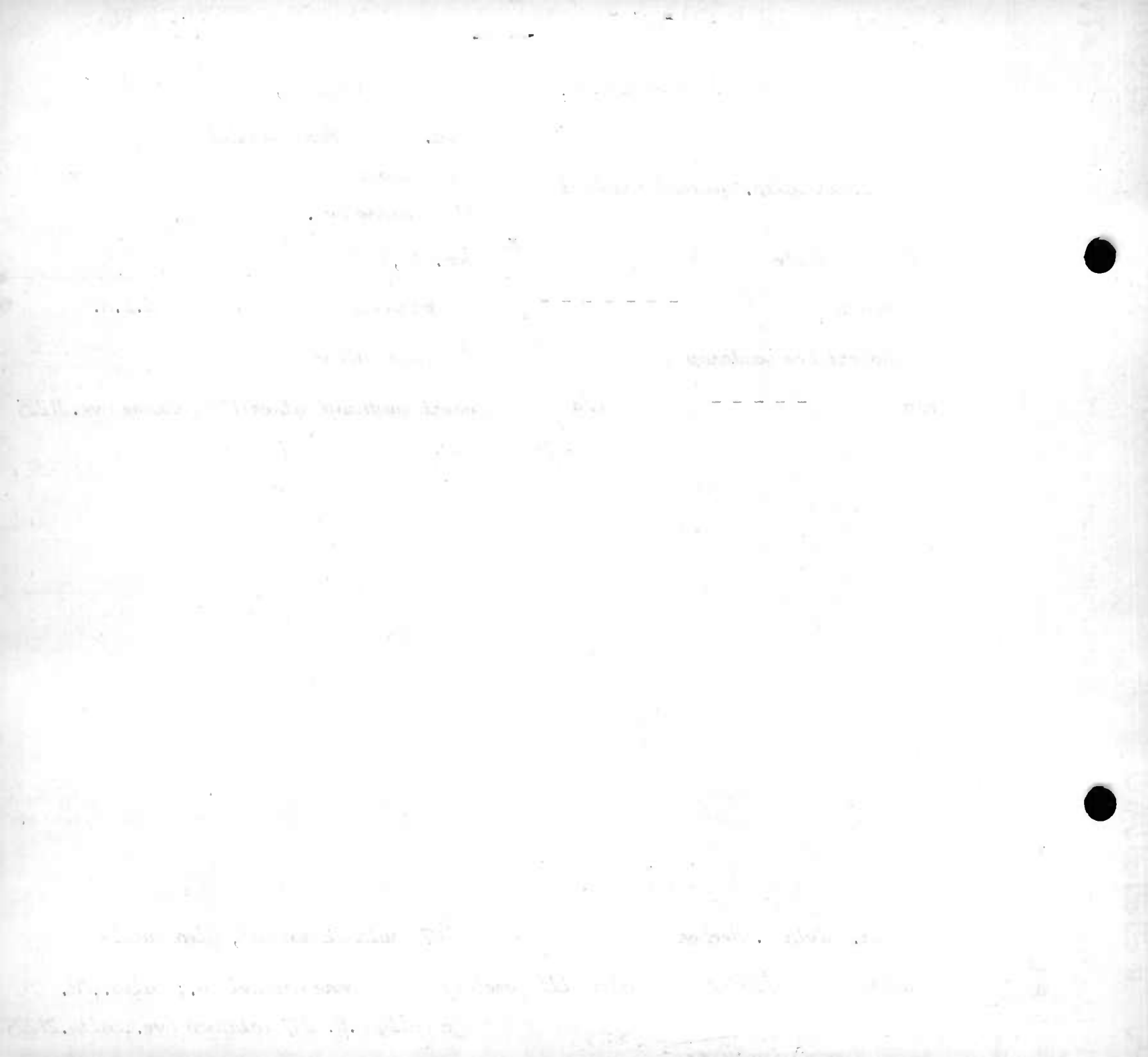
Age 12y Plome from Johns Hopkins Hospital - Medical Records. Miss Davis
JRS 955-6139

For Approval Approved by Medical Examiner

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 03848	
G-361 72 03848				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) Karen Michele Gauthrop				2. DATE AND HOUR OF DEATH April 18, 1972	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) DOA South Balto. General Hospital				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY Anne Arundel	
5. SEX F 6. RACE White 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH Jan. 14, 1967 9. AGE (In years lost birthday) 5	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) n/app				11. BIRTHPLACE (State or foreign country) Maryland	
10B. KIND OF BUSINESS OR INDUSTRY -----				12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Robert Lee Gauthrop				14. MOTHER'S MAIDEN NAME Lois Holcomb	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) n/a				16. SOCIAL SECURITY NO. n/a	
17. INFORMANT Robert Gauthrop (Father)				ADDRESS 118 Camrose Ave. 21225	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH Orthogryposis multiplex (This does not include conditions such as e.g., heart failure, asphyxia, shock, trauma, disease, injury, or complication which caused death.) ANTECEDENT CAUSES congenital				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 YEARS	
19. CHIEF OR ASST. MEDICAL EXAMINER DISEASES OR CONDITIONS, giving rise to the above cause, stating the UNDERLYING CONDITION last.				(B) _____ (C) _____	
20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). II					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from 3/14 19 67 to 1/18 19 72 , that (1) (we) lost saw the deceased alive on 1/18 19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Alvin W. Hecker				23B. DATE SIGNED 4/18/72	
23C. PHYSICIAN'S NAME (Type) Dr. Alvin W. Hecker				23D. ADDRESS 407 Crain Highway SE, Glen Burnie	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4/20/72		24C. NAME OF CEMETERY or CREMATORY Cedar Hill Cemetery	
24D. LOCATION Anne Arundel Co.; Balto., Md.		24E. STATE Md.			
25A. DATE REC'D BY HEALTH DEPT. APR 21 1972		25B. NAME OF REGISTRAR Robert E. Hecker		25C. FUNERAL DIRECTOR Mc Oully F.H. 237 Patapsco Ave., Balto. 21225	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. (Enc. Thomas Archer Monks, Jr.)		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 03849	
1. NAME OF DECEASED (Type or Print) MONKS, Thomas Archer, Jr.			2. DATE AND HOUR OF DEATH April 19, 1972 9:30 A.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Veterans Administration Hospital 3900 Loch Raven Blvd. Baltimore, Maryland 21218			4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE Maryland B. COUNTY Harford C. CITY OR TOWN Forest Hills D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 32 E. Jarrattsville Road		
5. SEX Male	6. RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-18-06	9. AGE (In years last birthday) 66	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truck Driver		10B. KIND OF BUSINESS OR INDUSTRY Md. State Rd. Comm.		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Archer Thomas Monks			14. MOTHER'S MAIDEN NAME Mary Ann Phillips Phelps		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) Yes 5-5-42 to 7-16-43 219-10-7551			16. SOCIAL SECURITY NO. 219-10-7551		
17. INFORMANT Records			ADDRESS VA Hospital 3900 Loch Raven Blvd., Balto., Md.		
18. CAUSE OF DEATH Post necrotic cirrhosis			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 Week		
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshtenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Acute renal failure (B) DUE TO, OR AS A CONSEQUENCE OF: Chronic obstructive lung disease With pneumonia (C) Hypotension		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg. etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that he (this hospital) attended the deceased from March 30, 1972 to April 19, 1972 , that we last saw the deceased alive on April 19, 1972 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Lawrence Mills, M.D.				23B. DATE SIGNED 4-19-72	
23C. PHYSICIAN'S NAME (Type) Lawrence Mills, M.D.				23D. ADDRESS 3900 Loch Raven Blvd. Balto., Md. 21218	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE April 21, 1972		24C. NAME OF CEMETERY or CREMATORY Rest Spring Episcopal Ch. Cemetery	
24D. LOCATION (City, town, or county) (State) Forest Hill, Harford Co., Maryland 21050		25A. DATE REC'D BY HEALTH DEPT. APR 21 1972			
25B. NAME OF REGISTRAR John E. Jones, M.D.		25C. FUNERAL DIRECTOR Joseph William Foster W. Broadway & Williams St. Bel Air, Maryland 21014			

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

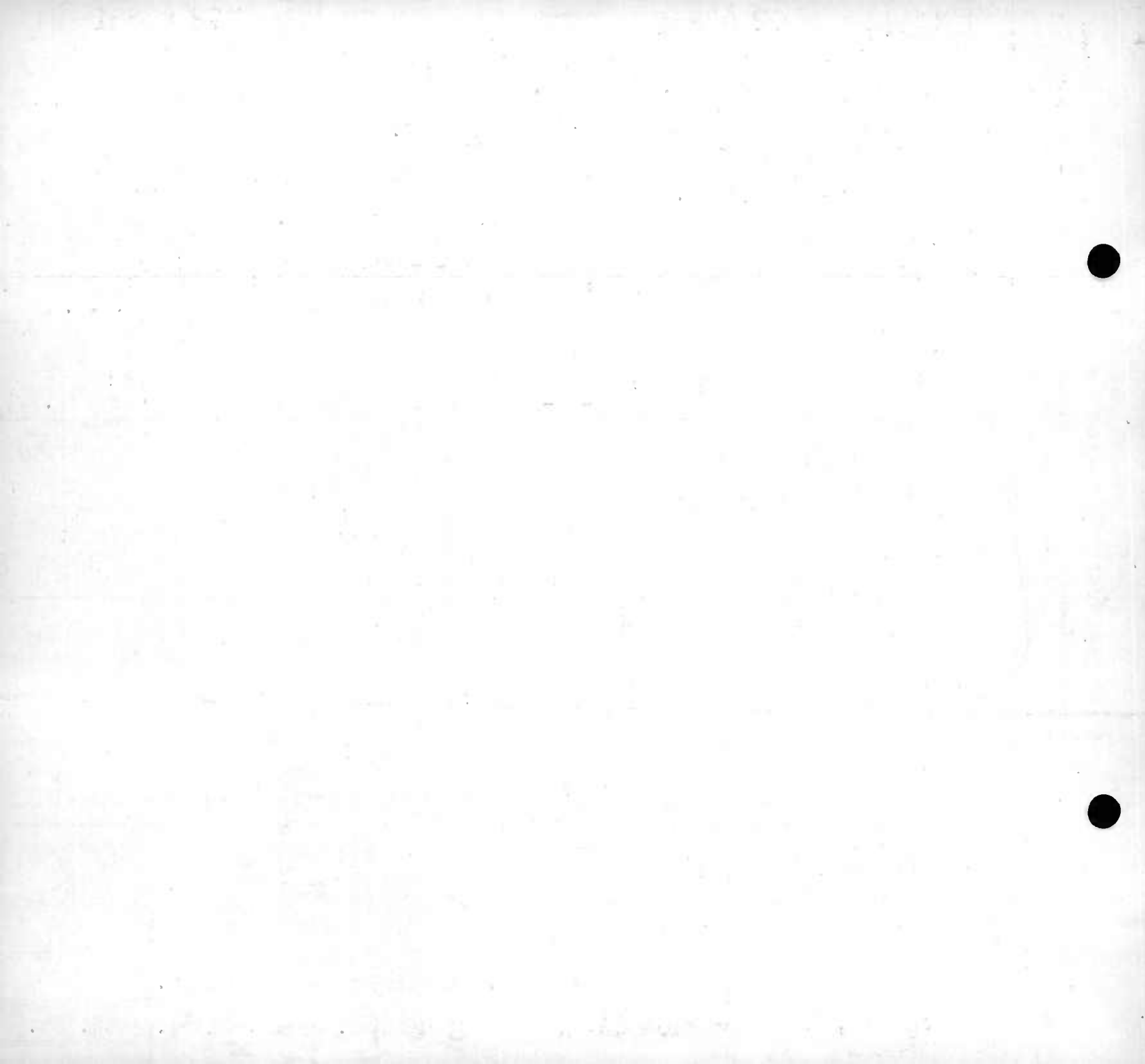
BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. 72-03850
BIRTH NO. <div style="font-size: 2em; font-weight: bold;">A-425</div> <div style="font-size: 1.5em;">72 03850</div>		1. NAME OF DECEASED (Type or Print) JOHN M. ALEXANDER, JR.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) UNIV. OF MD. HOSP. BALTO., MD 21201		2. DATE AND HOUR OF DEATH 4/19/72 1⁰⁰ A.M. 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD B. COUNTY HARRIS C. CITY OR TOWN STREET D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER RT 1, BOX 62 ENORY CHURCH RD.		
5. SEX M	6. RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-18-24	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) TECHNICIAN		10B. KIND OF BUSINESS OR INDUSTRY CHEMICAL		9. AGE (In years last birthday) 47 11. BIRTHPLACE (State or foreign country) GORMAN, MD. 12. CITIZEN OF WHAT COUNTRY? USA.
13. FATHER'S NAME JOHN M. ALEXANDER			14. MOTHER'S MAIDEN NAME OLIVE JENKINS	
15. Was Deceased Ever In U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES WW II		16. SOCIAL SECURITY NO. 220-16-6220		
17. INFORMANT BETTY M. ALEXANDER, STREET, MD.				
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 204.01 PROBABLE ACUTE I.C. HEMORRHAGE ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Thrombocytopenia Acute Lymphoblastic Leukemia				
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? NO
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		
21F. HOW DID INJURY OCCUR?				
22. I certify that (I) (this hospital) attended the deceased from 2/29/72 19 to 19 Apr 19 72 that (I) (we) last saw the deceased alive on 19 Apr 19 72 and that (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE P. A. MACKOWIAK		23B. DATE SIGNED 4/19/72		23C. PHYSICIAN'S NAME (Type) P. A. MACKOWIAK
23D. ADDRESS MD U. OF MD HOSPITAL		24A. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		
24B. DATE 4-21-72		24C. NAME OF CEMETERY OR CREMATORY FROSTBURG MEM. PARK		
24D. LOCATION (City, town, or county) (State) FROSTBURG, MD.		25A. DATE REC'D BY HEALTH DEPT. APR 21 1972		
25B. NAME OF REGISTRAR JOHN H. HARKINS		25C. FUNERAL DIRECTOR JOHN H. HARKINS, DELTA, PA.		



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

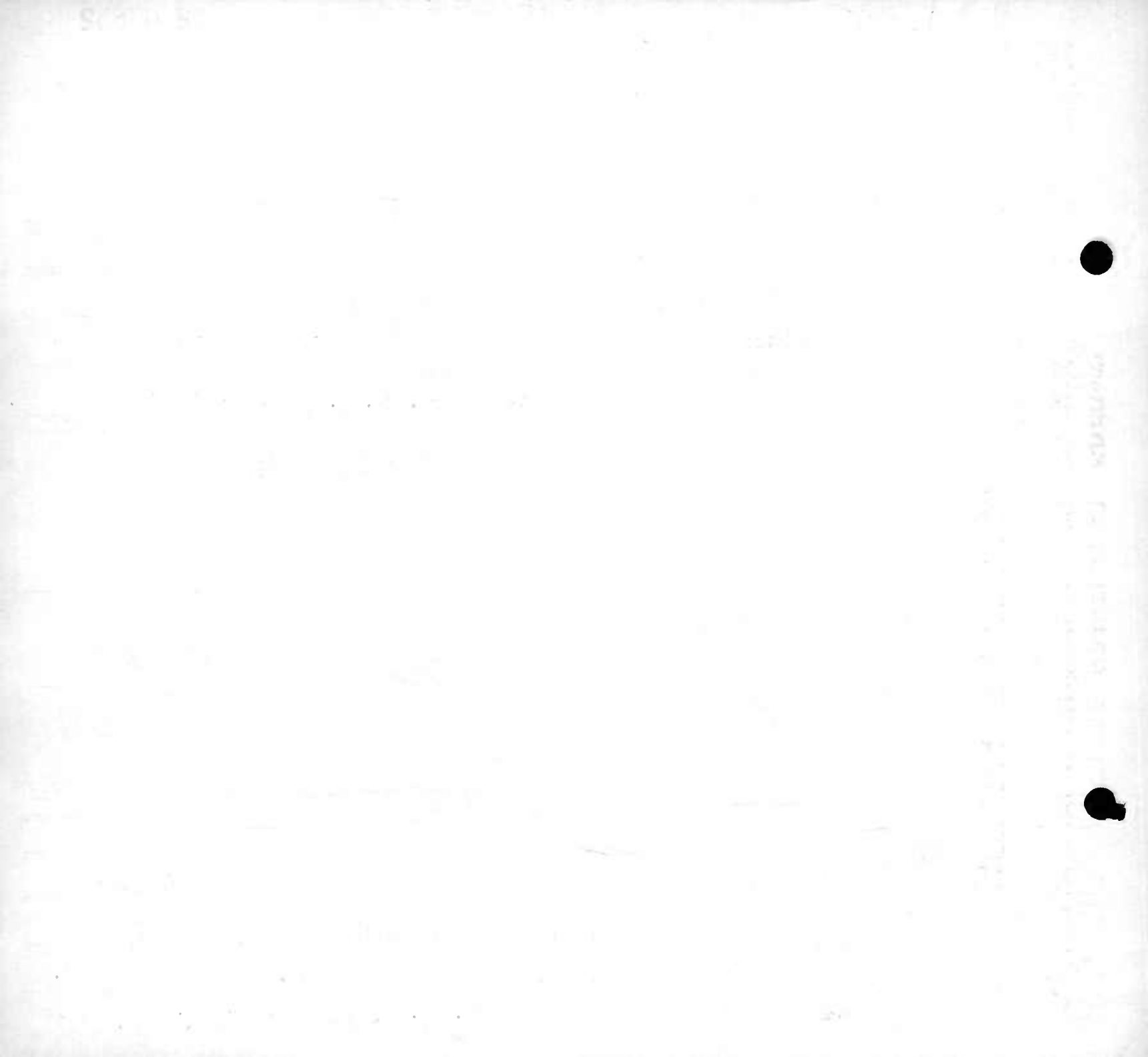
BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. 72 03851	
BIRTH NO. B 243			72 03851		
1. NAME OF DECEASED (Type or Print) <div style="text-align: center; font-size: 1.2em;">Dorothy W. Buckholt.</div>			2. DATE AND HOUR OF DEATH <div style="text-align: center; font-size: 1.2em;">April 17, 1972</div>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <div style="text-align: center; font-size: 1.2em;">00 805 Powers St.</div>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY 1306		
			C. CITY OR TOWN <div style="text-align: center; font-size: 1.2em;">Baltimore</div>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER <div style="text-align: center; font-size: 1.2em;">805 Powers St.</div>		
5. SEX <div style="text-align: center; font-size: 1.2em;">Female</div>	6. RACE <div style="text-align: center; font-size: 1.2em;">White</div>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <div style="text-align: center; font-size: 1.2em;">2/24-1914</div>	9. AGE (In years last birthday) <div style="text-align: center; font-size: 1.2em;">58</div>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <div style="text-align: center; font-size: 1.2em;">House Wife</div>		10B. KIND OF BUSINESS OR INDUSTRY <div style="text-align: center; font-size: 1.2em;">Home</div>		11. BIRTHPLACE (State or foreign country) <div style="text-align: center; font-size: 1.2em;">Maryland</div>	
12. CITIZEN OF WHAT COUNTRY? <div style="text-align: center; font-size: 1.2em;">U.S.A.</div>					
13. FATHER'S NAME <div style="text-align: center; font-size: 1.2em;">Edwin C Garrett</div>			14. MOTHER'S MAIDEN NAME <div style="text-align: center; font-size: 1.2em;">Bryley</div>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <div style="text-align: center; font-size: 1.2em;">no</div>		16. SOCIAL SECURITY NO. <div style="text-align: center; font-size: 1.2em;">213-14-3834</div>		17. INFORMANT <div style="text-align: center; font-size: 1.2em;">Monta Buckholt</div>	
				ADDRESS <div style="text-align: center; font-size: 1.2em;">805 Powers St.</div>	
18. 491X1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH <div style="text-align: center; font-size: 1.5em;">Oesodomeumose peritonice</div> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) <div style="text-align: center; font-size: 1.5em;">Stages chronic bronchitis emphysema</div> DUE TO, OR AS A CONSEQUENCE OF: (C) _____		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <div style="text-align: center; font-size: 1.5em;">legitimate fracture</div>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <div style="text-align: center; font-size: 1.5em;">3 months</div>		
19A. DATE OF OPERATION <div style="text-align: center; font-size: 1.2em;">0</div>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <div style="text-align: center; font-size: 1.2em;">Jan 14 1972</div> to <div style="text-align: center; font-size: 1.2em;">April 17 1972</div> , that (I) (we) last saw the deceased alive on <div style="text-align: center; font-size: 1.2em;">APRIL 4 1972</div> and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <div style="text-align: center; font-size: 1.5em;">DR. L. J. BERSOCK</div>				23B. DATE SIGNED <div style="text-align: center; font-size: 1.2em;">April 18/72</div>	
23C. PHYSICIAN'S NAME (Type) <div style="text-align: center; font-size: 1.2em;">3500 N. CALVERT ST.</div>				23D. ADDRESS <div style="text-align: center; font-size: 1.2em;">Lorraine Pk. Cemetery Baltimore, Md.</div>	
24A. BURIAL CREMATION, REMOVAL (Specify) <div style="text-align: center; font-size: 1.2em;">Burial</div>		24B. DATE <div style="text-align: center; font-size: 1.2em;">4/20/72</div>		24C. NAME OF CEMETERY or CREMATORY <div style="text-align: center; font-size: 1.2em;">Lorraine Pk. Cemetery</div>	
				24D. LOCATION (City, town, or county) (State) <div style="text-align: center; font-size: 1.2em;">Baltimore, Md.</div>	
25A. DATE REC'D BY HEALTH DEPT. <div style="text-align: center; font-size: 1.2em;">APR 21 1972</div>		25B. NAME OF REGISTRAR <div style="text-align: center; font-size: 1.2em;">Robert E. Seitz</div>		25C. FUNERAL DIRECTOR <div style="text-align: center; font-size: 1.2em;">Frank W. Seitz</div>	
				ADDRESS <div style="text-align: center; font-size: 1.2em;">814 W. 36th. St.</div>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

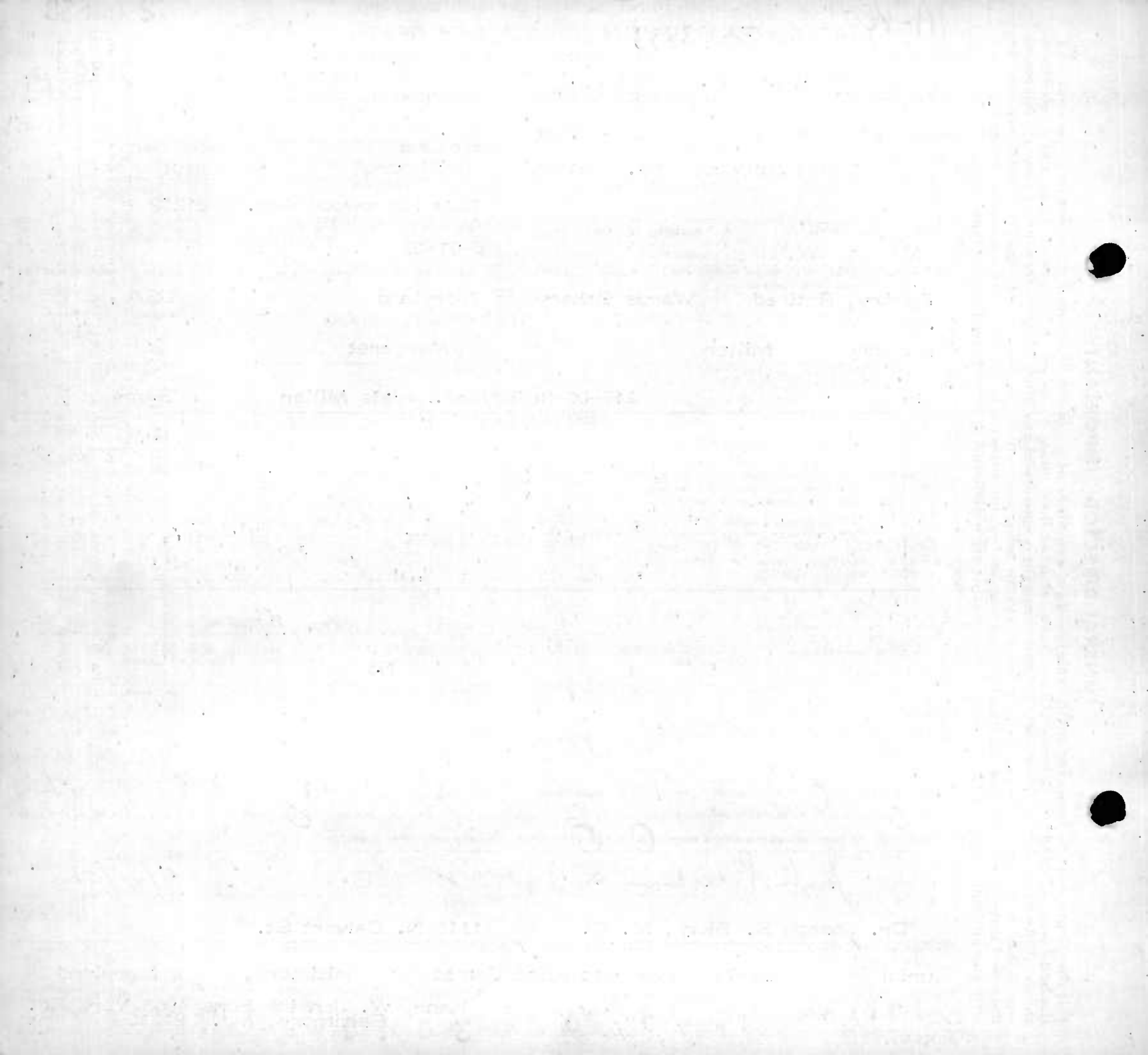
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>72 03852</u>	
J-525		72 03852		CERTIFICATE OF DEATH	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>BESSIE W. JOHNSON</u>		2. DATE AND HOUR OF DEATH <u>4/20/72</u> <u>1:10 P. M.</u>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>1201</u>		C. CITY OR TOWN <u>BALTIMORE</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
FULL NAME OF HOSPITAL OR INSTITUTION <u>MARYLAND GENERAL HOSPITAL</u>		E. STREET AND NUMBER <u>4206 TUSCANY CT.</u>			
5. SEX <u>F</u>	6. RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-23-89</u>	9. AGE (in years last birthday) <u>82</u>	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homemaker</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>John Wittbecker</u>		14. MOTHER'S MAIDEN NAME <u>Sarah Patton</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>213-20-2951</u>		17. INFORMANT ADDRESS <u>D Mrs. W. J. Lamm 4017 Villa Nova Rd.</u>	
18. <u>4-12-41</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>ASCVD with CHF</u> DUE TO, OR AS A CONSEQUENCE OF: (B) _____ DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>4/20/72</u> to <u>4/20</u> 19 <u>72</u> that (I) (we) last saw the deceased alive on <u>4/20</u> 19 <u>72</u> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Beltran, M.D.</u>		23B. DATE SIGNED <u>4/20/72</u>			
23C. PHYSICIAN'S NAME (Type) <u>JUAN A. BELTRAN M.D.</u>		23D. ADDRESS <u>MARYLAND GENERAL HOSP.</u>			
24A. BURIAL CREMATION REMOVAL (Specify) <u>Cremation</u>		24B. DATE <u>4-24-72</u>		24C. NAME of CEMETERY or CREMATORY <u>Greenmount</u>	
24D. LOCATION <u>Balto.</u>		24E. (City, town, or county) (State) <u>Md.</u>			
25A. DATE REC'D BY HEALTH DEPT. <u>APR 21 1972</u>		25B. NAME OF REGISTRAR <u>John E. Kelly, M.D.</u>		25C. FUNERAL DIRECTOR <u>H. W. Jenkins & Sons Co.</u>	
25D. ADDRESS <u>4005 York Road Balto., Md. 21212</u>					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				72 03853		72 03853	
M-460				72 03853		72 03853	
BIRTH NO.				72 03853			
1. NAME OF DECEASED (Type or Print) William R. Miller				2. DATE AND HOUR OF DEATH 4-19-72 2 30 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 1029 Homewood Ave. 21202				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Md. 1001 B. COUNTY C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 1029 Homewood Ave. 21202			
5. SEX M	6. RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8-31-02	9. AGE (In years last birthday) 69	10. If Under 1 Yr. Months: Days: Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bakery, Retired				10B. KIND OF BUSINESS OR INDUSTRY Wards Bakery		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA				13. FATHER'S NAME Henry Miller			
14. MOTHER'S MAIDEN NAME Margaret				15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no			
16. SOCIAL SECURITY NO. 215-05-2946				17. INFORMANT Mrs. Adele Miller			
18. ADDRESS Same				19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 19A. DATE OF OPERATION 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 20A. AUTOPSY? (Yes or No) No 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner) 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> 21F. HOW DID INJURY OCCUR? 22. I certify that (I) (this hospital) attended the deceased from 2/28 1972 to 4/8 1972, that (I) (we) last saw the deceased alive on 4/7 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (Did) (did not) view the body after death. 23A. SIGNATURE Dr. Joseph S. Blum, M. D. 23B. DATE SIGNED 4/20/72 23C. PHYSICIAN'S NAME (Type) Dr. Joseph S. Blum, M. D. 23D. ADDRESS 1115 N. Calvert St. 24A. BURIAL CREMATION, REMOVAL (Specify) Burial 24B. DATE 4-22-72 24C. NAME OF CEMETERY OR CREMATORY New Cathedral Cemetery 24D. LOCATION (City, town, or county) (State) Baltimore, Maryland 25A. DATE REC'D BY HEALTH DEPT. APR 21 1972 25B. NAME OF REGISTRAR Henry W. Jenkins 25C. FUNERAL DIRECTOR Henry W. Jenkins Sons 25D. ADDRESS 4905 York Rd. Baltimore, Md. 21212			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
72 03854 CERTIFICATE OF DEATH									
BIRTH NO. REG. NO. 72 03854									
1. NAME OF DECEASED (Type or Print) <u>Mc Hale, Charlotte L.</u>					2. DATE AND HOUR OF DEATH <u>4-19-72 15⁴⁵ P.M.</u>				
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD					4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)				
FULL NAME OF HOSPITAL OR INSTITUTION <u>Maryland General Hospital</u>					A. STATE <u>Maryland</u> B. COUNTY <u>2768</u>				
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)					C. CITY OR TOWN <u>Balto</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
E. STREET AND NUMBER <u>Dartmouth Rd - 806</u>									
5. SEX <u>F</u>	6. RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>11-6-20</u>	9. AGE (In years last birthday) <u>51 yrs</u>	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			10B. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>Roy J. Snied</u>					14. MOTHER'S MAIDEN NAME <u>Albaugh</u>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>			16. SOCIAL SECURITY NO. <u>219-18-3503</u>		17. INFORMANT ADDRESS <u>Michael J. Mc Hale (Same)</u>				
18. CAUSE OF DEATH									
<div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> <p>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</p> <p>(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)</p> <p>ANTECEDENT CAUSES</p> <p>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p> </div> <div style="width: 50%;"> <p>CAUSE OF DEATH</p> <p>(A) IMMEDIATE CAUSE <u>CACHEXIA - MALNUTRITION</u> DUE TO, OR AS A CONSEQUENCE OF:</p> <p>(B) <u>CARCINOMA STOMACH</u> DUE TO, OR AS A CONSEQUENCE OF:</p> <p>(C) _____</p> </div> <div style="width: 10%; text-align: center;"> <p>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</p> <p><u>6 mos.</u></p> </div> </div>									
<p style="text-align: center;">II</p> <p>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>VASCULAR INSUFFICIENCY / MYXEDEMA</u></p>									
19A. DATE OF OPERATION <u>0</u>			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>NO</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)			21E. INJURY OCCURRED While At <input type="checkbox"/> Not While <input type="checkbox"/> Work At Work		21F. HOW DID INJURY OCCUR?				
22. I certify that (this hospital) attended the deceased from <u>3-18</u> 19 <u>72</u> to <u>4-19</u> 19 <u>72</u> , that (we) last saw the deceased alive on <u>4-19</u> 19 <u>72</u> and that in (my) <u>own</u> opinion death occurred on the date and hour and from the causes stated above. (I) <u>did</u> (did not) view the body after death.									
23A. SIGNATURE <u>Henry G. Sacks</u>					Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>			23B. DATE SIGNED <u>4-19-72</u>	
23C. PHYSICIAN'S NAME (Type) <u>HENRY G. SACKS</u>					23D. ADDRESS <u>Md. GEN. Hosp.</u>				
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>			24B. DATE <u>4-22-72</u>		24C. NAME of CEMETERY or CREMATORY <u>Moreland Memorial Park</u>		24D. LOCATION (City, town, or county) (State) <u>Balto. Co. Md.</u>		
25A. DATE REC'D BY HEALTH DEPT. <u>APR 21 1972</u>			25B. NAME OF REGISTRAR <u>Robert E. Jenkins</u>		25C. FUNERAL DIRECTOR <u>H. W. Jenkins & Sons Co.</u> ADDRESS <u>4005 York Road Balto., Md. 21212</u>				

4/25/72 - Letter from General direction Jfc.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

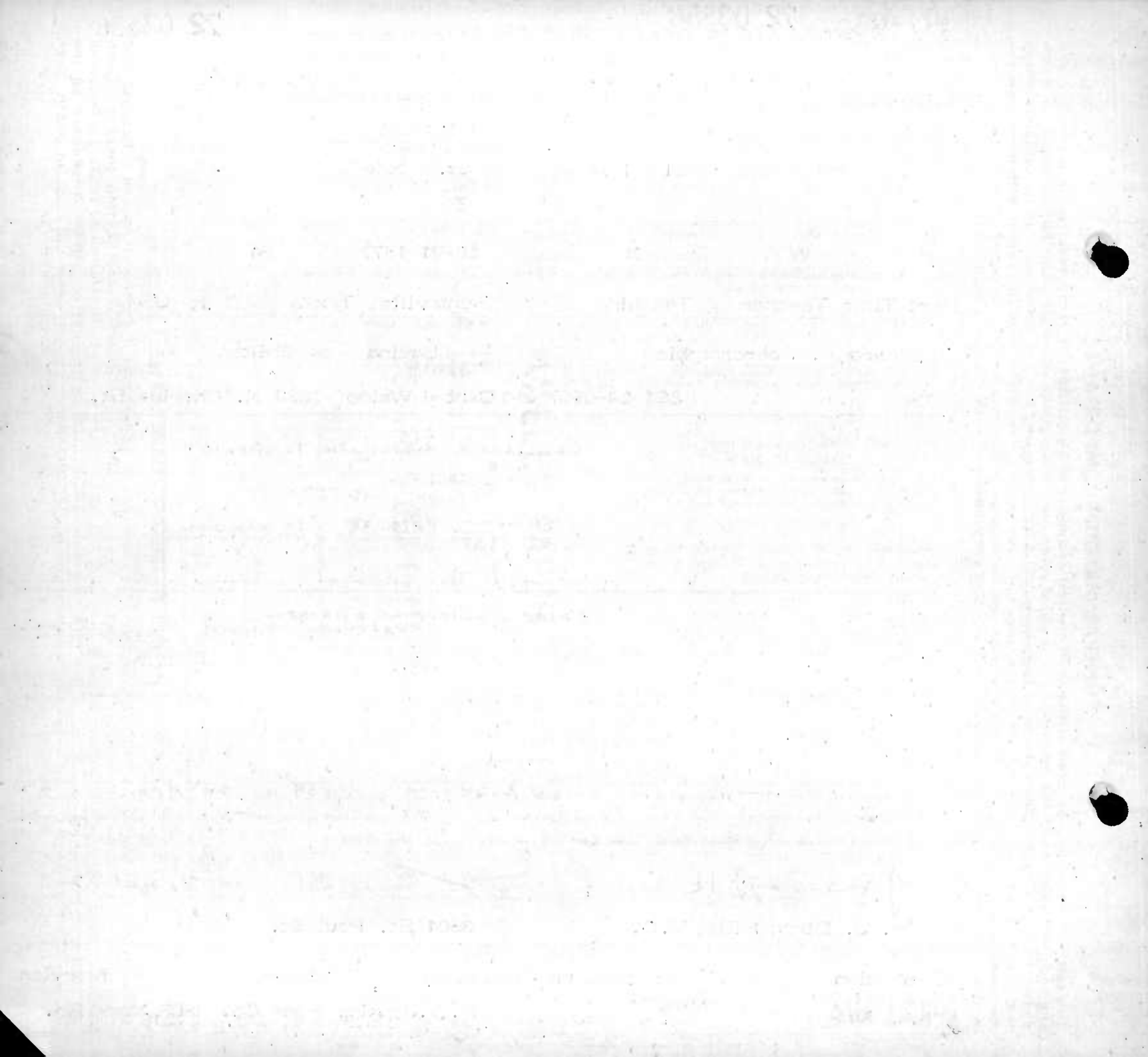
G 653 72 03855		BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		REG. NO. 72 03855	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) GARNETT Thomas		2. DATE AND HOUR OF DEATH 4-16-72 01-AM			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY 1207		C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
FULL NAME OF HOSPITAL OR INSTITUTION Union Memorial Hospital		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		E. STREET AND NUMBER 2616 NILES AVE.			
5. SEX M	6. RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-24-98	9. AGE (In years last birthday) 74	10. Under 1 Yr. Months: Days: Hours: Min.	11. BIRTHPLACE (State or foreign country) Virginia	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT		ADDRESS					
18. 43691		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: C. U. A.					
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) Arterio sclerosis DUE TO, OR AS A CONSEQUENCE OF:					
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No) No	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from 4-15-1972 to 4-16-1972 that (I) (we) last saw the deceased alive on 4-16-1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE G. Battilana MD		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 4-16-72			
23C. PHYSICIAN'S NAME (Type) DR. A. BATTILANA		23D. ADDRESS ANATOMY BOARD OF MARYLAND JOHNS HOPKINS MEDICAL SCHOOL					
24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE 4-18-72	24C. NAME OF CEMETERY or CREMATOR					
25A. DATE REC'D BY HEALTH DEPT. APR 21 1972	25B. NAME OF REGISTRAR Robert E. Talley	25C. NAME OF SECTION MORTUARY SERVICE - BCHD		ADDRESS			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>72 03856</u>	
W-430 72 03856		CERTIFICATE OF DEATH			
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		Corinne A. Waldo		April 20, 1972 3:30 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION 90 Long Green Nursing Home			A. STATE B. COUNTY Missouri V22		
			C. CITY OR TOWN St. Louis		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> ? NO <input type="checkbox"/>
			E. STREET AND NUMBER 2		
5. SEX F	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-21-1877	9. AGE (In years last birthday) 94	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Part Time Teacher		10B. KIND OF BUSINESS OR INDUSTRY Teaching		11. BIRTHPLACE (State or foreign country) Huntsville, Texas	
12. CITIZEN OF WHAT COUNTRY? USA					
13. FATHER'S NAME Leonard A. Abercrombie			14. MOTHER'S MAIDEN NAME Lavina Chilton		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 521-34-8997 J-1		17. INFORMANT ADDRESS Gentry Waldo 3333 N. Charles St.	
18. <u>198.3</u> I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH CARCINOMA, METASTATIC TO BRAIN (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: CARCINOMA, PRIMARY SITE UNKNOWN (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 2		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			ATRIO SEPTIC CARDIAC VASCULAR DISEASE 2 YEARS		
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (has <u>did</u>) attended the deceased from <u>NOVEMBER 19 69</u> to <u>20 APRIL 19 72</u> , that (I) (last <u>last</u>) saw the deceased alive on <u>11 APRIL 19 72</u> and that in (my) (last <u>last</u>) opinion death occurred on the date and hour and from the causes stated above. (I) (was <u>did</u>) (not <u>did</u>) view the body after death.					
23A. SIGNATURE <u>J. R. Dixon</u>			23B. DATE SIGNED 21 APR 72		23C. PHYSICIAN'S NAME (Type) Dr. J. Dixon Hills, M.D.
23D. ADDRESS 3501 St. Paul St.					
24A. BURIAL CREMATION, REMOVAL (Specify) Cremation		24B. DATE 4-20-72		24C. NAME OF CEMETERY or CREMATORY Greenmount Crematory	
24D. LOCATION Baltimore		24E. (City, town, or county)		24F. (State) Maryland	
25A. DATE RECD BY HEALTH DEPT. APR 21 1972		25B. NAME OF REGISTRAR J. W. Jenkins		25C. FUNERAL DIRECTOR H. W. Jenkins Sons Co. 4905 York Rd. Baltimore, Md. 21212	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

A-420		72 03857		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 03857	
BIRTH NO.				1. NAME OF DECEASED (Type or Print) ALICIA, BILLIE (ARLISHIA)			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				2. DATE AND HOUR OF DEATH April 19, 1972 9⁴⁰ P.M.			
FULL NAME OF HOSPITAL OR INSTITUTION George Washington Nursing Home 609 Pennsylvania Ave		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MD. B. COUNTY 1205		C. CITY OR TOWN Baltimore, Md	
5. SEX Female		6. RACE Negro		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9/23/28	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Nurse's Aide		10B. KIND OF BUSINESS OR INDUSTRY		9. AGE (in years, last birthday) 43		11. BIRTHPLACE (State or foreign country) Red Spring, North Car.	
13. FATHER'S NAME William Parker				14. MOTHER'S MAIDEN NAME Sarah ?			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. ?		17. INFORMANT Chart		ADDRESS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ADENOCARCINOMA OF LUNG				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 MOS.			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (1) (this hospital) attended the deceased from 14 APR 1972 to APR 19 72 that (1) (we) last saw the deceased alive on APR 18 19 72 and that (1) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Richard Lydon, MD				23B. DATE SIGNED APR 19 72		23C. PHYSICIAN'S NAME (Type)	
23D. ADDRESS							
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE 4/24/72		24C. NAME OF CEMETERY or CREMATORY Mt. Calvary Cem		24D. LOCATION (City, town, or county) (State) Anne Arundel City Md.	
25A. DATE REC'D BY HEALTH DEPT. APR 21 1972		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR WMC MARCH			
				ADDRESS 928 E North Ave			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 03858	
CERTIFICATE OF DEATH					
BIRTH NO. D-200 72 03858		1. NAME OF DECEASED (Type or Print) <i>Diggs Ida Mae</i>		2. DATE AND HOUR OF DEATH <i>4-18-72 7:10 PM</i>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Md.</i> B. COUNTY <i>908</i>		
FULL NAME OF HOSPITAL OR INSTITUTION <i>49 North Charles Gen Hosp</i> <i>2724 N. Charles ST</i>			C. CITY OR TOWN <i>BALTO</i>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
5. SEX <i>F</i> 6. RACE <i>Negro</i> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH <i>2/16/87</i>		9. AGE (In years last birthday) <i>85</i>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>			10B. KIND OF BUSINESS OR INDUSTRY <i>-</i>		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>
13. FATHER'S NAME <i>Nesikia Johnson</i>			14. MOTHER'S MAIDEN NAME <i>Mary Johnson</i>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO. <i>217-05-2528</i>		17. INFORMANT <i>Hosp. Chart</i>
18. <i>151.9 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <i>Respiratory failure</i> <i>multiple metastases</i> <i>Ca, stomach</i>			CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>1 day</i> <i>4 months</i> <i>6 months</i>
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION <i>10-23-72</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Ca stomach</i>		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (N) (this hospital) attended the deceased from <i>April 18</i> 19 <i>72</i> to <i>April 18</i> 19 <i>72</i> that (I) (we) last saw the deceased alive on <i>April 18</i> 19 <i>72</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Aurora Payabyab M.D.</i>				23B. DATE SIGNED <i>4-18-72</i>	
23C. PHYSICIAN'S NAME (Type) <i>AURORA A. PAYABYAB M.D.</i>				23D. ADDRESS <i>NORTH CHARLES HOSPITAL</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>4/22/72</i>		24C. NAME OF CEMETERY OR CREMATORY <i>Pleasant Rest Cem</i>	
24D. LOCATION <i>Towson Md.</i>		25A. DATE REC'D BY HEALTH DEPT. <i>APR 21 1972</i>			
25B. NAME OF REGISTRAR <i>Robert F. Taylor</i>		25C. FUNERAL DIRECTOR <i>WMC MARCH</i>			
25D. ADDRESS <i>928 E NORTH AVE</i>					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

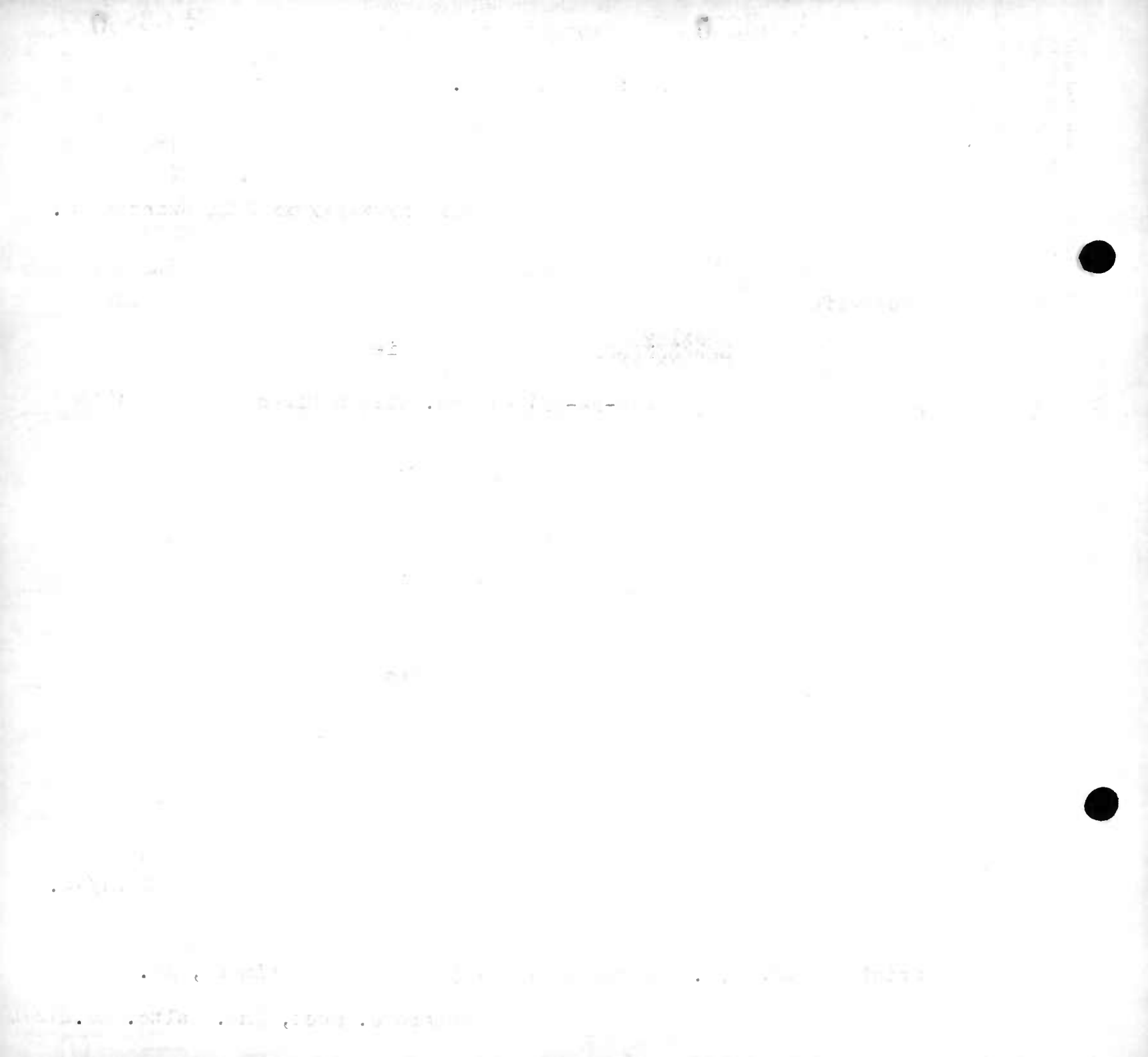
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 03859	
BIRTH NO. 72 03859		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) Wendell Johnson		2. DATE AND HOUR OF DEATH 4-17-72			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (If NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 1700 Chilton Street		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY 906			
5. SEX Male		6. RACE Negro		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY Chemical Co.		8. DATE OF BIRTH 1-23-13 9. AGE (In years last birthday) 59	
11. BIRTHPLACE (State or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Walter Johnson		14. MOTHER'S MAIDEN NAME			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes WWII		16. SOCIAL SECURITY NO.		17. INFORMANT Barbara Johnson	
18. 250.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CORONARY THROMBOSIS ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. ARTERIO SCLEROSIS AND HYPERTENSION		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 24 HRS.	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). EMPHYSEMA (LUNG)				6 MOS.	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from OCT 15 19 71 to MARCH 14 19 72 that (I) (we) last saw the deceased alive on MARCH 14 19 72 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE ALBERT R. WILKINSON M.D.				23B. DATE SIGNED 4/20/72	
23C. PHYSICIAN'S NAME (Type) Albert R. Wilkinson M.D.				23D. ADDRESS 1200 ST. PAUL ST. BALTO. Md.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4-21-72		24C. NAME OF CEMETERY or CREMATORY Baltimore Cemetery	
24D. LOCATION Balto., Md.		25A. DATE REC'D BY HEALTH DEPT. APR 21 1972			
25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR Wm O March			
25D. ADDRESS 928 E. North Ave.					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <u>M-240 72 03860</u>				BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		REG. NO. <u>72 03860</u>	
1. NAME OF DECEASED (Type or Print) <u>MASKELL; ANNIE O.</u>				2. DATE AND HOUR OF DEATH <u>4/21/72 112.05 P.M.</u>					
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <u>44 Union Memorial Hospital</u>				4. USUAL RESIDENCE (Where deceased lived. If institutions residence before admission) A. STATE <u>Md</u> B. COUNTY <u>2758</u>					
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>44 Union Memorial Hospital</u>				C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
				E. STREET AND NUMBER <u>2044 Swansea Rd.</u>					
5. SEX <u>F</u>	6. RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>3-16-91</u>	9. AGE (In years last birthday) <u>81</u>	10. If Under 1 Yr. Months: Days: Hours: Min.		11. If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>GEORGE Baxley</u>				14. MOTHER'S MAIDEN NAME <u>MARIE JORDAN</u>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>218-52-1317</u>		17. INFORMANT <u>Mrs. Eileen Hires</u>		ADDRESS <u>(Same)</u>	
18. <u>444.91</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <u>Hypovolemic shock</u>				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Acute renal failure - ASCVD</u>					
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Multiple Emboli c/o bleeding</u>				(B) DUE TO, OR AS A CONSEQUENCE OF: (C) <u>Multiple Emboli c/o bleeding</u>					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).									
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>Yes</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from <u>3-28</u> 19 <u>72</u> to <u>4-21</u> 19 <u>72</u> that (I) (we) last saw the deceased alive on <u>4-21</u> 19 <u>72</u> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <u>[Signature]</u>				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>4/21/72.</u>			
23C. PHYSICIAN'S NAME (Type) <u>Michael Nahes</u>		DEGREE <u>M.D.</u>		23D. ADDRESS <u>Union Memorial Hospital</u>					
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>4/24/72.</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Parkwood Cemetery</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>			
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR <u>Leonard J. Ruck, Inc. Balto. Md. 21214</u>					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Baltimore City Health Department				REG. NO. 72 03861	
P-360 72 03861		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) POTTER, JO ANN C.		2. DATE AND HOUR OF DEATH 4/20/72 2:30 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION JOHNS HOPKINS HOSPITAL		A. STATE MARYLAND		B. COUNTY 2757	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER 50532 Pk 2801 Harview Ave			
5. SEX F	6. RACE Cauc N	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/16/48	9. AGE (In years last birthday) 23	10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NURSE ANDE		10B. KIND OF BUSINESS OR INDUSTRY BLUE SHIELD		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME JAMES H POTTER		14. MOTHER'S MAIDEN NAME GERTRUDE SEGREST	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 212-48-9900		17. INFORMANT Mr James H Potter	
18. 070X1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) HEPATIC ENCEPHALOPATHY		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH DAYS			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: ACUTE HEPATIC NECROSIS		DAYS	
		(B) DUE TO, OR AS A CONSEQUENCE OF: INFECTIOUS HEPATITIS		WEEKS	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) NO	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 4/14 19 72 to 4/20 19 72 that (I) (we) last saw the deceased alive on 4/20 19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Robert C Bast Jr MD				23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) ROBERT C. BAST, JR MD				23D. ADDRESS JOHNS HOPKINS HOSPITAL	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4/24/72		24C. NAME OF CEMETERY OR CREMATORY Parkwood	
24D. LOCATION (City, town, or county) (State) Baltimore, Maryland		25A. DATE REC'D BY HEALTH DEPT. APR 24 1972			
25B. NAME OF REGISTRAR Robert C. Bast Jr		25C. FUNERAL DIRECTOR Leonard J Buck Inc. Baltimore, Md			

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

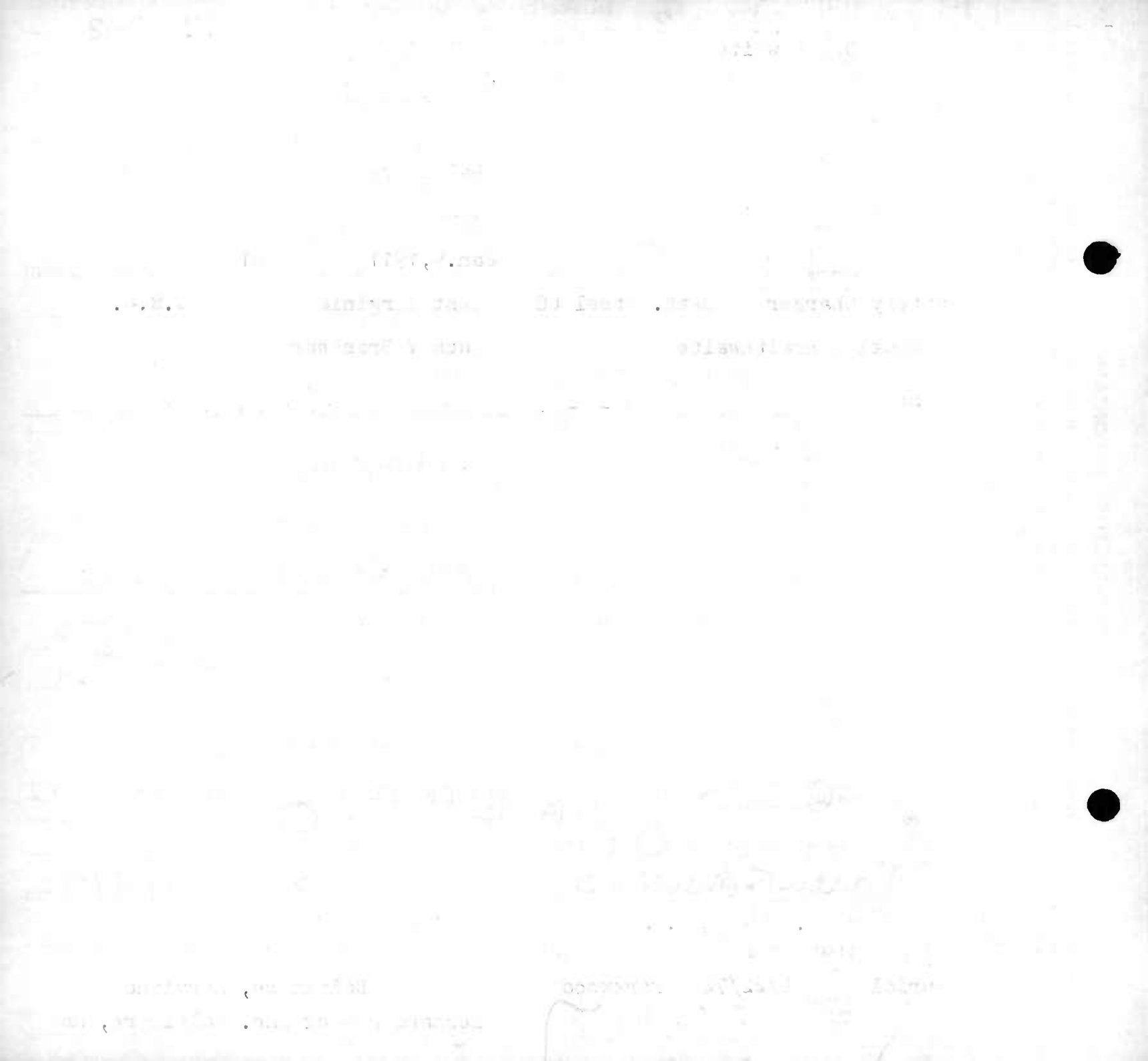
100-100000

49-02-17 djr

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-633 72 03862		BALTIMORE CITY HEALTH DEPT.		CERTIFICATE OF DEATH		REG. NO. 72 03862	
BIRTH NO. Braithwaite		1. NAME OF DECEASED (Type or Print) Braithwaite, Vernon J		2. DATE AND HOUR OF DEATH 4-19-72 11 30 A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE Maryland B. COUNTY Baltimore			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland 21224				C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
				E. STREET AND NUMBER 7319 Stratton Way 21224			
5. SEX Male	6. RACE Caucasian	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 9, 1911	9. AGE (In years last birthday) 61	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Battery Charger		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Battery Charger			10B. KIND OF BUSINESS OR INDUSTRY Beth. Steel CO		11. BIRTHPLACE (State or foreign country) West Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Samuel J Braithwaite				14. MOTHER'S MAIDEN NAME Ruth V Brashear			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 213-07-4880		17. INFORMANT BCH: RECORDS Baltimore, Maryland		ADDRESS 4940 Eastern Avenue 21224	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Cardiogenic Shock 1 hr. (B) MASSIVE MYOCARDIAL INFARCT 4 hrs. (C) PULMONARY EDEMA 1 hr. (R)LL atelectasis yrs.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (1) (this hospital) attended the deceased from 4-19-72 19 to 4-19-72 19 that (I) (we) last saw the deceased alive on 4-19-72 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Karen F. O'Neill M.D.				23B. DATE SIGNED 4/19/72		23C. PHYSICIAN'S NAME (Type) Karen F. O'Neill, M.D.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial				24B. DATE 4/22/72		24C. NAME of CEMETERY or CREMATORY Parkwood	
24D. LOCATION Baltimore, Maryland				24E. ADDRESS 4940 Eastern Avenue Baltimore, Maryland 21224		24F. CITY, TOWN, or county (State)	
25A. DATE REC'D BY HEALTH DEPT. APR 24 1972				25B. NAME OF REGISTRAR Robert E. Taylor, Jr.		25C. FUNERAL DIRECTOR Leonard J Ruck Inc. Baltimore, Md	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

T-620 72 03863		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 03863	
BIRTH NO.			CERTIFICATE OF DEATH		
1. NAME OF DECEASED (Type or Print) TRICKA FRANKLIN			2. DATE AND HOUR OF DEATH 4-19-72		8:25 p. m.
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 33 The Johns Hopkins Hospital			4. USUAL RESIDENCE (Where deceased lived, if institutions residence before admission) A. STATE MD. B. COUNTY 2632 C. CITY OR TOWN BAITIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 4202 Rayman Ave.		
5. SEX Male	6. RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-5-24	9. AGE (In years last birthday) 48	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Court Clerk		10B. KIND OF BUSINESS OR INDUSTRY State of Maryland		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY USA			13. FATHER'S NAME Frank J. Tricka		
14. MOTHER'S MAIDEN NAME Josephine S. Sirvack			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes W W II		
16. SOCIAL SECURITY NO. 219-12-5241		17. INFORMANT Miss Doris J. Tricka		ADDRESS Same	
18. CAUSE OF DEATH 431.0 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CEREBRAL EDEMA ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. INTRACEREBRAL HEMATOMA HYPERTENSION			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 DAY 1 1/2 DAYS 10 YEARS		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 3-4-18-72		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED INTRACEREBRAL HEMATOMA		20A. AUTOPSY? (Yes or No) Yes	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? No		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH? Inotify medical examined <input type="checkbox"/> No			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) No		21C. WHERE DID INJURY OCCUR? No			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) No		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> No			
21F. HOW DID INJURY OCCUR? No		22. I certify that (I) (this hospital) attended the deceased from 18 APRIL 19 72 to 19 APRIL 19 72 that (I) (we) last saw the deceased alive on 19 APRIL 19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE Karl Stetcher, Jr. M.D.			23B. DATE SIGNED 4-19-72		23C. PHYSICIAN'S NAME (Type) Karl Stetcher, Jr. MD.
23D. ADDRESS The Johns Hopkins Hospital			24A. BURIAL CREMATION, REMOVAL (Specify) Burial		
24B. DATE 4/24/72		24C. NAME of CEMETERY or CREMATORY Gardens of Faith Cem.		24D. LOCATION (City, town, or county) (State) Baltimore Maryland	
25A. DATE REC'D BY HEALTH DEPT. ADD 24 1072		25B. NAME OF REGISTRAR R. L. G. E. Fisher, M.D.		25C. FUNERAL DIRECTOR Leonard J. Ruck Inc.	
ADDRESS 5305 Harford Rd.					

RECEIVED
FEB 10 1964
U.S. DEPT. OF JUSTICE
FEDERAL BUREAU OF INVESTIGATION

TO : DIRECTOR, FBI (100-388610)
FROM : SAC, NEW YORK (100-100000) (P)
SUBJECT: [Illegible]
RE: [Illegible]
[The remainder of the document contains several paragraphs of extremely faint, illegible text, likely a teletype or memorandum. The text is mirrored and difficult to decipher.]

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Baltimore City Health Department				REG. NO. 72 03864	
7-520 72 03864		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
FUNK, DORA A.		4/21/72		7:20 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION 44 Univ Memorial Hospital		A. STATE Maryland		B. COUNTY 2634	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER 1016 Armstead Way			
5. SEX F	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-13-89	9. AGE (In years last birthday) 83 82	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) W. VIRGINIA	
13. FATHER'S NAME ANDREW BOLYARD		14. MOTHER'S MAIDEN NAME LYDIA BOLNER		12. CITIZEN OF WHAT COUNTRY? AMERICAN	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 216-40-1907		17. INFORMANT Mrs Elizabeth Wilson	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). 19A. DATE OF OPERATION 0		CAUSE OF DEATH (A) IMMEDIATE CAUSE Pneumonia. Septicemic shock DUE TO, OR AS A CONSEQUENCE OF: (B) ASCVD - Diabetic Mellitus DUE TO, OR AS A CONSEQUENCE OF: (C) Anemia.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 4/19/1972 to 4/21/1972, that (I) (we) last saw the deceased alive on 4/21/1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE M.D. DEGREE		23B. DATE SIGNED 4/21/72			
23C. PHYSICIAN'S NAME (Type) Ghoshan Nohas M.D.		23D. ADDRESS UHM. Balto-Md 21218			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4/24/72		24C. NAME OF CEMETERY or CREMATORY Mt Israel	
24D. LOCATION Tunnelton, West Virginia		24E. (City, town, or county) (State)			
25A. DATE REC'D BY HEALTH DEPT. APR 24 1972		25B. NAME OF REGISTRAR Leopold JORuck Inc.		25C. FUNERAL DIRECTOR Baltimore, Md	

RECEIVED

NOV 19 1976

U.S. DEPARTMENT OF JUSTICE

FEDERAL BUREAU OF INVESTIGATION

WASHINGTON, D.C. 20535

TO : DIRECTOR, FBI

FROM : SAC, NEW YORK

SUBJECT: [Illegible]

RE: [Illegible]

DATE: 11/19/76

TIME: 10:00 AM

BY: [Illegible]

FOR: [Illegible]

THRU: [Illegible]

INFO: [Illegible]

NOTES: [Illegible]

ATTACHMENTS: [Illegible]

DISTRIBUTION: [Illegible]

ADMINISTRATIVE: [Illegible]

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

T-400 72 03865		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 03865	
BIRTH NO.			1. NAME OF DECEASED (Type or Print) MR EARLE N. TULL		
2. DATE AND HOUR OF DEATH 4/19/72 11 22 AM			3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY BALTO			FULL NAME OF HOSPITAL OR INSTITUTION UNION MEMORIAL HOSPITAL		
C. CITY OR TOWN TOWSON			D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
E. STREET AND NUMBER 8527 DRUMWOOD ROAD					
5. SEX MALE	6. RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 07/18/08	9. AGE (in years last birthday) 63	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) TRANSFERRED CLERK		10B. KIND OF BUSINESS OR INDUSTRY WESTERN ELECTRIC		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME JOSEPH TULL			
14. MOTHER'S MAIDEN NAME SARAH (UNION) PEREGOY		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO			
16. SOCIAL SECURITY NO. 215-01-3766		17. INFORMANT Ruth E. TULL Same as #4E			
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) G-I BLEEDING - RENAL FAILURE (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 3 4/17/72		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED PYLOROPLASTY, VAGOTOMY, GASTROSTOMY		20A. AUTOPSY (Yes or No) <input checked="" type="checkbox"/>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from 4/13/72 19 to 4/19/72 1972 that (1) (we) last saw the deceased alive on 4/19/72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE V. V. V. V.				23B. DATE SIGNED 4/19/72	
23C. PHYSICIAN'S NAME (Type) VIRA VISESHSINDH				23D. ADDRESS UNION MEMORIAL HOSPITAL	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4-22-72		24C. NAME of CEMETERY or CREMATORY First United Evangelical Church Cemetery	
24D. LOCATION Baltimore		24E. STATE Md.			
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR Wm. Cook-Brooks Towson, Inc. Towson Md.	



B-423

72 03866

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 72 03866

BIRTH NO.

1. NAME OF DECEASED (Type or Print) ELLEN MARJORIE BLACKSTOCK		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year April 19, 1972 M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 00 6806 Hallbridge Sturbridge Drive		3. DATE PRONOUNCED DEAD Month Day Year Hour April 19, 1972 1:50 P. M.	
6. SEX Female		7. RACE White	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore	
9. DATE OF BIRTH April 22, 1918		10. AGE (in years lost birthday) 53	
11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James Letts		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Home maker	
15. MOTHER'S MAIDEN NAME Anna Clift		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No	
17. SOCIAL SECURITY NO. 219-01-2331		18. INFORMANT ADDRESS Donald B. Blackstock Same as #5E	
19. 412.4 CAUSE OF DEATH Arteriosclerotic cardiovascular disease		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(B) DUE TO, OR AS A CONSEQUENCE OF:	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		(C)	
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) Yes			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?			
22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?			
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Charles S. Springate M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Charles S. Springate, M.D.		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED April 20, 1972	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4-22-72	
24C. NAME OF CEMETERY OR CREMATORY Moreland Memorial Park		24D. LOCATION (City, town, or county) (State) Parkville Md.	
25A. DATE REC'D BY HEALTH DEPT. APR 24 1972		25B. NAME OF REGISTRAR Robert E. [Signature]	
25C. FUNERAL DIRECTOR Wm. Cook-Briggs Towson, Inc.		ADDRESS Towson, Md.	

4-28-1972 - Completion of cause of death on a pending medical examiner death certificate
Charles S. Springate, M.D.

HRS

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. 72 03867
1. NAME OF DECEASED (Type or Print) Lottie G. Matheny		2. DATE AND HOUR OF DEATH April 18, 1972 6:25 P.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY BALTO		
FULL NAME OF HOSPITAL OR INSTITUTION Johns Hopkins Hospital 33		C. CITY OR TOWN Rosedale		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
5. SEX Female		6. RACE Caucasian		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		10B. KIND OF BUSINESS OR INDUSTRY		8. DATE OF BIRTH May 18, 1902
13. FATHER'S NAME William G. O'Daniell		14. MOTHER'S MAIDEN NAME MARY EMILY CAUDLE		9. AGE (In years last birthday) 69
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 213 09 04100		11. BIRTHPLACE (State or foreign country) North Carolina
17. INFORMANT Mary Waters 7930 Philadelphia Road		12. CITIZEN OF WHAT COUNTRY? USA		
18. 402X1 + 011.9 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Ac. heart failure		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Hypertensive heart disease (B) DUE TO, OR AS A CONSEQUENCE OF: Arteriosclerosis.		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		Tuberculosis, avian type		
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Initially medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from August 12, 1970 to April 18, 1972 that (I) (we) last saw the deceased alive on April 17, 1972 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE Robert Roubenoff		23B. DATE SIGNED 4/20/72		23C. PHYSICIAN'S NAME (Type) ROBERT ROUBENOFF
23D. ADDRESS Ridge Road Baltimore 21237		24. BURIAL CREMATION, REMOVAL (Specify) Burial		
24A. DATE 4-22-72		24B. NAME OF CEMETERY OR CREMATORY Oak Lawn Cemetery		24C. LOCATION (City, town, or county) (State) Baltimore, Maryland
25A. DATE REC'D BY HEALTH DEPT. APR 24 1972		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR 1211 Chesaco Avenue



1

P-625 72 03868

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 72 03868

BIRTH NO.

1. NAME OF DECEASED (Type or Print) JENNINGS R. PERKINS		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION CHURCH HOME AND HOSPITAL (DOA)		3. DATE PRONOUNCED DEAD Month Day Year April 19, 1972 Hour 4:10 A.M.	
6. SEX Male		7. RACE White	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY 2634	
9. DATE OF BIRTH 8/27/28		10. AGE (In years lost birthday) 43 If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) TENN.		12. CITIZEN OF WHAT COUNTRY? USA	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE		14B. KIND OF BUSINESS OR INDUSTRY	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) YES WWII		17. SOCIAL SECURITY NO. 220-24-2589	
18. INFORMANT JAMES PERKINS		ADDRESS 5 RT. RUDDEN CT	
19. CAUSE OF DEATH 412.7 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)		22E. INJURY OCCURRED. WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?		21. AUTOPSY? (Yes or No) yes	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE EXAMINER'S NAME (Type) Ronald N. Kornblum, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 4/19/72			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 4/22/72	
24C. NAME OF CEMETERY or CREMATORY CEDAR HILL		24D. LOCATION (City, town, or county) (State) BALTO. MD.	
25A. DATE REC'D BY HEALTH DEPT. APR 24 1972		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.	
25C. FUNERAL DIRECTOR J.G. CONNELLY		ADDRESS 300 MACE	

VS 151-REV. 1/1/68

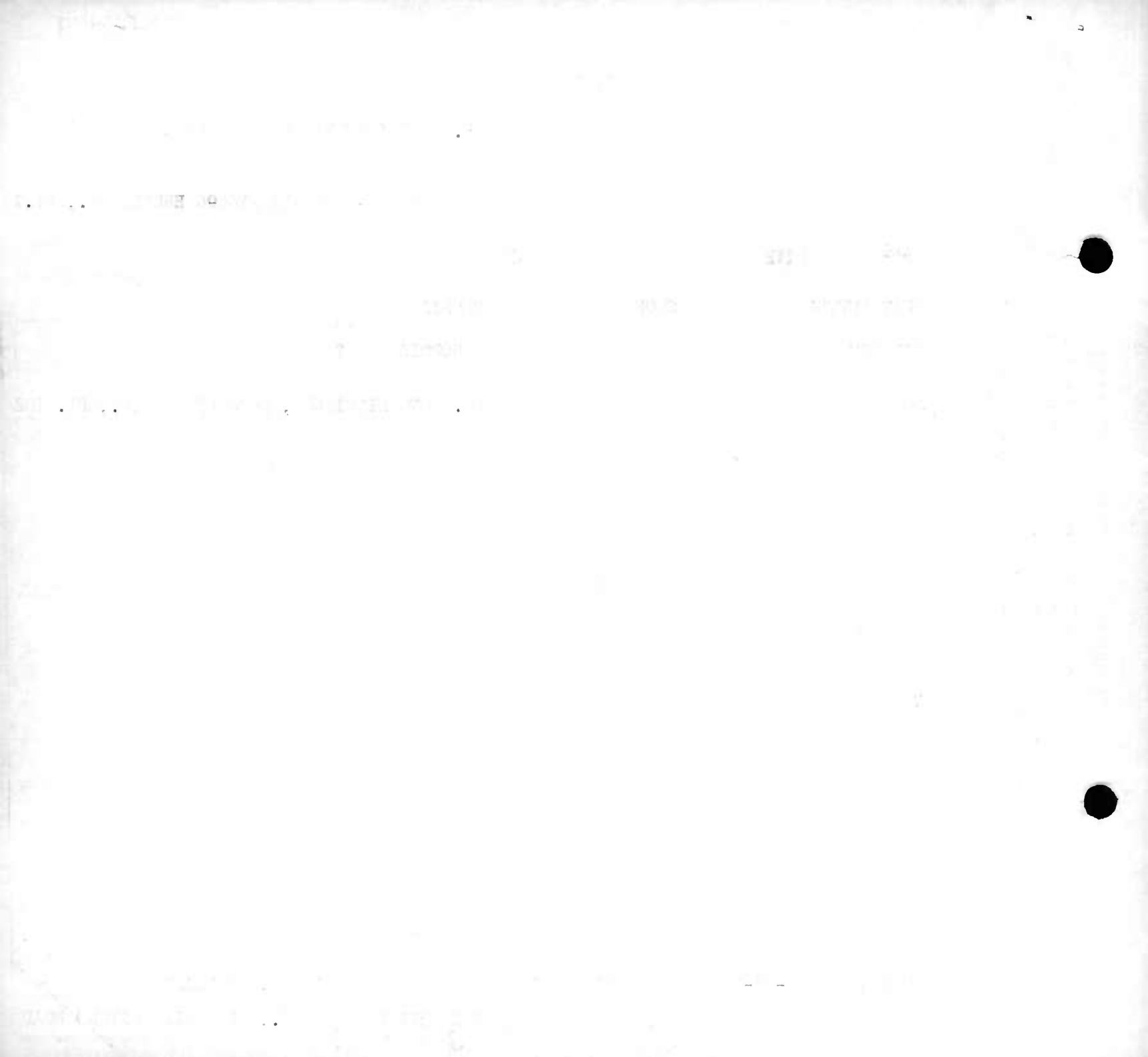
4-28-1972 - Completion of cause of death on a pending medical examiner death certificate

Ronald N. Kornblum, M.D. HRS

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Baltimore City Health Department				REG. NO. 72 03869	
BIRTH NO. 72 03869		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) ASH, MORRIS (MAURICE)		2. DATE AND HOUR OF DEATH 4-20-72 8:07 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 42 Sinai Hospital of Baltimore		A. STATE MD. B. COUNTY 2831			
		C. CITY OR TOWN Beth		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER XXXXXXX6606 EBERLE DR., APT. 102			
5. SEX MALE	6. RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 61	9. AGE (In years last birthday)	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MEAT CUTTER		10B. KIND OF BUSINESS OR INDUSTRY SHOP		11. BIRTHPLACE (State or foreign country) RUSSIA	
13. FATHER'S NAME MAX ASH		14. MOTHER'S MAIDEN NAME SOPHIA ?			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS MRS. RUTH EINBINDER, 6606 EBERLE DR., APT. 102	
18. 226.2.1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH			
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Cerebrovascular Accident			
ANTECEDENT CAUSES		(B) DUE TO, OR AS A CONSEQUENCE OF: Pituitary Tumor			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (if this hospital) attended the deceased from 4-20-72 to 4-20-72 that (if we) last saw the deceased alive on 4-20-72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Adolph S. Victoria		23B. DATE SIGNED 4-20-72		23C. PHYSICIAN'S NAME (Type) Adolfo S. Victoria	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 4-21-72		24C. NAME OF CEMETERY OR CREMATORY ANSHE KOLK WOLYN	
25A. DATE REC'D BY HEALTH DEPT. APR 24 1972		25B. NAME OF REGISTRAR Valerie E. Taylor, M.D.		25C. FUNERAL DIRECTOR ADDRESS SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD	



R-150

72 03870

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

72 03870

BIRTH NO.

1. NAME OF DECEASED (Type or Print) BENJAMIN RUBIN		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> April 19, 1972 M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Bon Secours Hospital, (DOA)		3. DATE PRONOUNCED DEAD Month Day Year Hour April 19, 1972 5:05 P. M.	
5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY BALTO 5302		6. SEX Male 7. RACE White 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH 9/21/1922 10. AGE (In years last birthday) 49 If Under 1 Yr. 11 Under 24 Hrs. Months Days Hours Min.		C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
11. BIRTHPLACE (State or foreign country) BALTIMORE, MARYLAND 12. CITIZEN OF WHAT COUNTRY? USA		E. STREET AND NUMBER 6203 Norvo Road	
13. FATHER'S NAME MAX RUBIN		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) GROCER 14B. KIND OF BUSINESS OR INDUSTRY RETAIL	
15. MOTHER'S MAIDEN NAME ROSE KLASS		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) YES W.W. II	
17. SOCIAL SECURITY NO. 217-14-1445		18. INFORMANT ADDRESS MR. JOSEPH RUBIN, 6203 NORVO ROAD #21207	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Gunshot wound of chest (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) Yes	
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIB-UTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Store	
22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 2601 W. Fayette St. 2002		22D. TIME (Month) (Day) (Year) (Hour) (Approx.) 4-12-72 4:37 P. m.	
22E. INJURY OCCURRED WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR? Shot during robbery	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Charles S. Springate, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED April 20, 1972	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 4-23-72	
24C. NAME OF CEMETERY or CREMATORY BETH JACOB ANSHE VESHEAR		24D. LOCATION (City, town, or county) (State) ROSEDALE, MARYLAND	
25A. DATE REC'D BY HEALTH DEPT. APR 24 1972		25B. NAME OF REGISTRAR Robert E. Rubin, M.D.	
25C. FUNERAL DIRECTOR SOL LEVINSON & BROS. INC., 6010 REISTERSTOWN ROAD		ADDRESS	

6-840 ST

75 10370

65

WAX DRYIN

USA

BAITMENT, MARYLAND

BOON KLAS

RETAIL

CHOCER

YES W.M. 11 11-14-1948 MR. JOSEPH BROWN, 4002 BROADWAY, NEW YORK

UNITED STATES DEPARTMENT OF JUSTICE

1-22-75

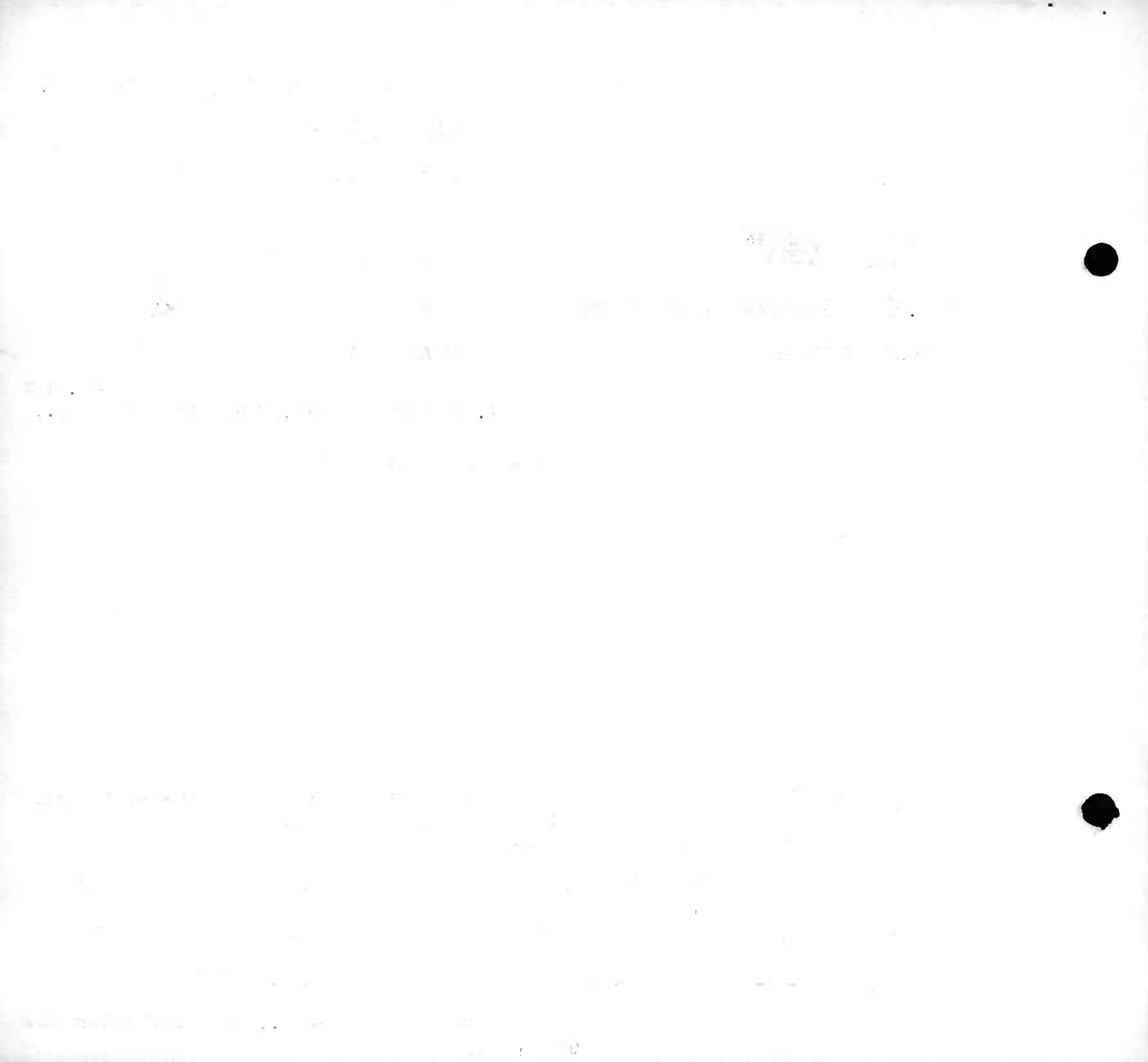
UNITED

FOR INFORMATION & RECORD

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Baltimore City Health Department CERTIFICATE OF DEATH				REG. NO. <u>72 03871</u>
BIRTH NO. <u>N-235</u>		72 03871		
1. NAME OF DECEASED (Type or Print) <u>Samuel Nachtomi</u>		2. DATE AND HOUR OF DEATH <u>April 20, 1972</u> <u>8:00 A.M.</u>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <u>Singai Hospital of Baltimore</u>		A. STATE <u>Md.</u> B. COUNTY <u>Balt.</u>		
(If not in hospital or institution, give street address or location)		C. CITY OR TOWN <u>Baltimore</u>		
<u>42</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
5. SEX <u>MALE</u>		E. STREET AND NUMBER <u>3421 Glen Av.</u>		
6. RACE <u>WHITE</u>		8. DATE OF BIRTH <u>11-15-04</u>		
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		9. AGE (In years lost birthday) <u>67</u>		
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11. BIRTHPLACE (State or foreign country)		
ELECT. <u>XXXXXX</u>		POLAND		
10B. KIND OF BUSINESS OR INDUSTRY		12. CITIZEN OF WHAT COUNTRY?		
SELF EMPLOYED		USA		
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		
YOSEPH NACHTOMI		SARAH ?		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		
NO		17. INFORMANT		
		ADDRESS APT. T 2		
		MR. ABRAHAM NACHTOMI, 6726 BONNIE RIDGE DR.,		
18. <u>162.1</u> I		CAUSE OF DEATH		
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		(A) IMMEDIATE CAUSE <u>Carcinoma of lung</u>		
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		DUE TO, OR AS A CONSEQUENCE OF:		
ANTECEDENT CAUSES		(B) DUE TO, OR AS A CONSEQUENCE OF:		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) _____		
II		Pneumonia		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		7 weeks		
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
				No
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		
22. I certify that (1) (this hospital) attended the deceased from <u>3-28</u> 19 <u>72</u> to <u>4-20</u> 19 <u>72</u>				
that (1) (we) last saw the deceased alive on <u>4-20</u> 19 <u>72</u> and that (1) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <u>Joshua Frankel MD</u>				23B. DATE SIGNED <u>4-20-72</u>
23C. PHYSICIAN'S NAME (Type) <u>Joshua Frankel MD</u>				23D. ADDRESS <u>Singai Hospital of Balt.</u>
24A. BURIAL CREMATION REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY
BURIAL		4-21-72		BETH JACOB
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR
APR 24 1972 <u>Robert E. Fisher, Jr.</u>				SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD
VS 150-REV. 1/1/68		3 8 6 6		



BIRTH NO.

1. NAME OF DECEASED
(Type or Print)ALVIN
ISRAEL ~~XAKEN~~ LEVIN2. DATE
OF
DEATHKnown ☒ Estimated ☐

Month

Day

Year

Hour

April 19, 1972

M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL
OR INSTITUTION(If not in hospital or institution, give street
address or location)

St. Agnes Hospital (DOA)

3. DATE
PRONOUNCED DEAD

Month

Day

Year

Hour

April 19, 1972

10:43 A.

M.

5. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)

A. STATE

Maryland

B. COUNTY

BALTO

530

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☐NO ☐

6. SEX

Male

7. RACE

White

8. MARRIED ☒NEVER MARRIED ☐WIDOWED ☐DIVORCED ☐

9. DATE OF BIRTH

MARCH 14, 1914

10. AGE (In years
lost birthday)

58

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

E. STREET AND NUMBER

6500 Sanzo Road, Apt. D

11. BIRTHPLACE (State or foreign country)

BALTIMORE, MARYLAND

12. CITIZEN OF
WHAT COUNTRY?

U S A

13. FATHER'S NAME

JACOB LEVIN

14A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

PHARMACIST

14B. KIND OF BUSINESS OR INDUSTRY

DRUG STORE

15. MOTHER'S MAIDEN NAME

REBECCA DIENER

16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

NO

17. SOCIAL
SECURITY NO.

212-07-8265

18. INFORMANT

ADDRESS

MRS. LEAH LEVIN, 6500 SANZO ROAD #21209

19. 412.4

CAUSE OF DEATH

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH

Arteriosclerotic cardiovascular disease

(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART I (A).

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

No

22A. EXTERNAL CAUSE WAS
UNDERLYING ☐ OR CONTRIB-
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg., etc.)22C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?22D. TIME (Month) (Day) (Year) (Hour)
OF INJURY
(APPROX.)

22E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Charles S. Springate, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

April 20, 1972

24A. BURIAL CREMATION,
REMOVAL (Specify)

BURIAL

24B. DATE

4-20-72

24C. NAME of CEMETERY or CREMATORY

ANSHE EMUNAH

24D. LOCATION (City, town, or county)

BALTIMORE, MARYLAND

(State)

25A. DATE REC'D BY HEALTH DEPT.

APR 24 1972

25B. NAME OF REGISTRAR

Robert E. Taylor, M.D.

25C. FUNERAL DIRECTOR

ADDRESS

SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD

57-1015

10-10-10

10-10-10

10

10-10-10

10-10-10

10-10-10

10-10-10

10-10-10

10-10-10

10-10-10

10-10-10

10-10-10

10-10-10

10-10-10

10-10-10

10-10-10

10-10-10

10-10-10

10-10-10

10-10-10

10-10-10

10-10-10

10-10-10

10-10-10

10-10-10

10-10-10

10-10-10

10-10-10

10-10-10

10-10-10

10-10-10

10-10-10

10-10-10

10-10-10

10-10-10

10-10-10

10-10-10

10-10-10

10-10-10

10-10-10

10-10-10

10-10-10

10-10-10

10-10-10

10-10-10

10-10-10

10-10-10

10-10-10

10-10-10

10-10-10

L-516

72 03873 BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 72 03873

BIRTH NO.

1. NAME OF DECEASED (Type or Print) DORAL C. LAMBERT		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 38 UNIVERSITY HOSPITAL		3. DATE PRONOUNCED DEAD Month Day Year Hour April 21, 1972 5:55 A. M.	
5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY 2102			
6. SEX Male	7. RACE White	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH 11-8-1929		10. AGE (in years last birthday) 40 If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) West Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Ours		14. STREET AND NUMBER 1341 Glyndon Avenue 21223	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truck Driver		14B. KIND OF BUSINESS OR INDUSTRY Koppers Company	
15. MOTHER'S MAIDEN NAME Edna Lambert			
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) Yes 1946-1948		17. SOCIAL SECURITY NO. 216-22-6379	
18. INFORMANT Mrs. Wanda L. Lambert, 1341 Glyndon Ave.		ADDRESS 21223	
19. 412.4 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
20. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) yes			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?			
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE EXAMINER'S NAME (Type) Ronald N. Kornblum, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 4/21/72			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4-24-1972	
24C. NAME OF CEMETERY or CREMATORY Loudon Park Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. APR 24 1972		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.	
25C. FUNERAL DIRECTOR Howard H. Hubbard, 4107 Wilkens Ave. 21229		ADDRESS	

ST. LOUIS

ST. LOUIS

ST. LOUIS

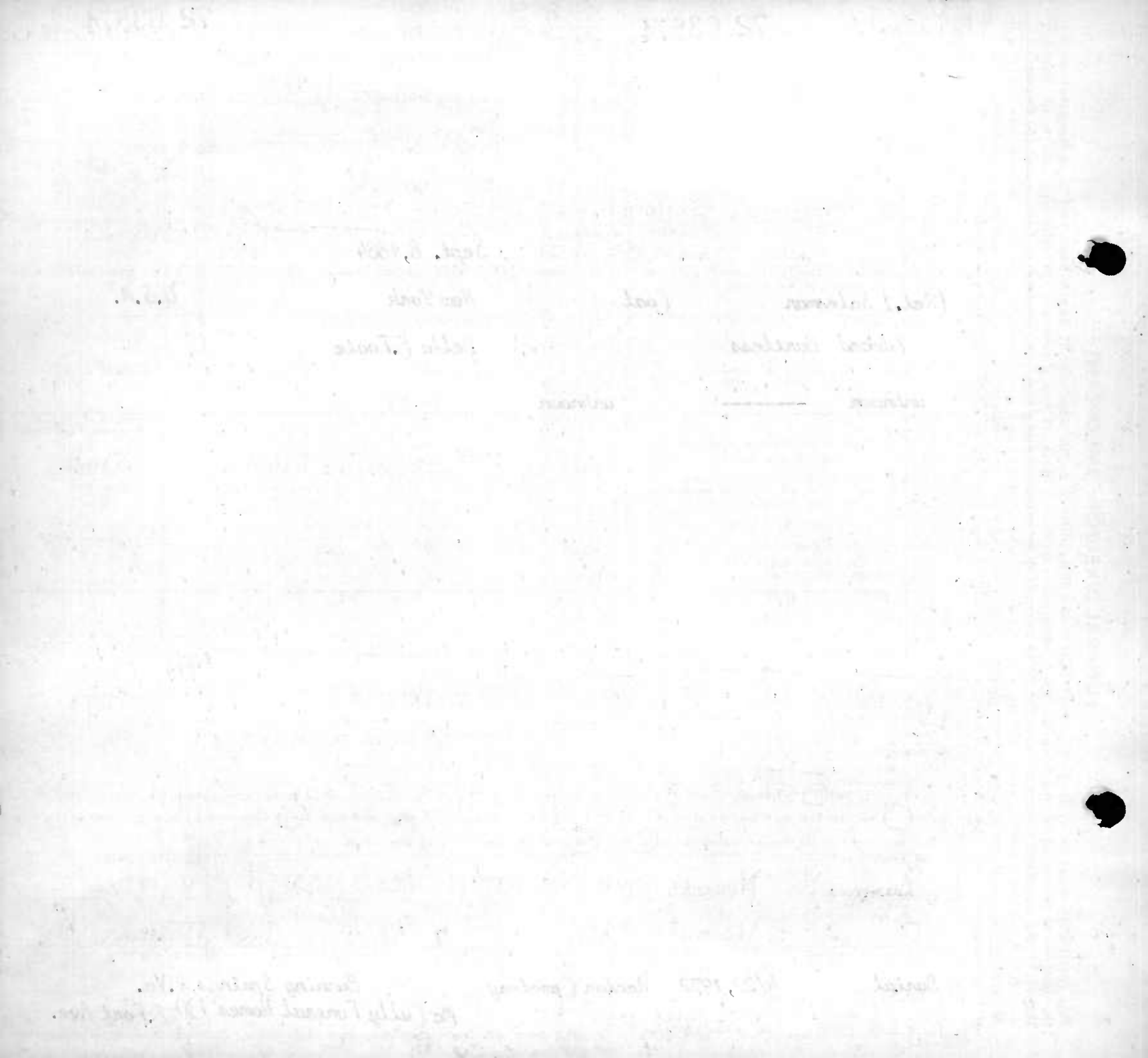
ST. LOUIS



FUNERAL DIRECTOR: IMPORTANT

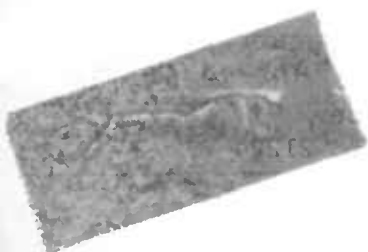
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-634 72 03874				BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 03874	
BIRTH NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) Martin Burtless				2. DATE AND HOUR OF DEATH 4/19/72 6 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 2534			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) South Baltimore General Hosp.				C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER 504 Maude Ave.			
5. SEX M	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 8, 1884		9. AGE (In years last birthday) 88	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) (Ret.) Salesman		10B. KIND OF BUSINESS OR INDUSTRY Coal		11. BIRTHPLACE (State or foreign country) New York		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Edward Burtless				14. MOTHER'S MAIDEN NAME Della E. Foote			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Unknown				16. SOCIAL SECURITY NO. unknown		17. INFORMANT chant	
18. 514 X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Pulmonary Edema ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 19A. DATE OF OPERATION 0 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED no 20A. AUTOPSY? (Yes or No) no 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 hrs.			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 4/19 1972 to 4/19 1972 , that (I) (we) last saw the deceased alive on 4/19 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Gwynne L. Horwits, MD. OEGREE				23B. DATE SIGNED 4/19/72		23C. PHYSICIAN'S NAME (Type) Gwynne L. Horwits, M.D. OEGREE	
23D. ADDRESS 2009 Sudgrave Ave., Baltimore, Md.							
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4/22, 1972		24C. NAME OF CEMETERY or CREMATORY Rector Cemetery		24D. LOCATION (City, town, or county) (State) Burning Springs, W. Va.	
25A. DATE REC'D BY HEALTH DEPT. APR 24 1972		25B. NAME OF REGISTRAR Robert E. Fisher, Jr.		25C. FUNERAL DIRECTOR Mc Cully Funeral Homes		25D. ADDRESS 130 E. Fort Ave.	



C-652 72 03875		BALTIMORE CITY HEALTH DEPARTMENT		72 03875	
BIRTH NO.				REG. NO.	
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH	
CORNISH FRANK				APR 14, 72 12 P. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				A. STATE B. COUNTY	
BALTIMORE CITY HOSPITAL 4940 Eastern Avenue Baltimore, Maryland 21224				MARYLAND 1802	
5. SEX		6. RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	
MALE		NEGRO		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		8. DATE OF BIRTH	
Laborer				2-5-90	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME	
???				???	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.	
17. INFORMANT				ADDRESS	
BCH RECORDS:				4940 Eastern Avenue 21224	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of death, e.g., heart failure, asphyxia, etc., but the disease, injury or complication which caused death.)					
DISEASE OR CONDITION CAUSING DEATH (If any, giving rise to the above)				(A) IMMEDIATE CAUSE	
SEPTICAEMIA				DUE TO, OR AS A CONSEQUENCE OF:	
(B) 3RD DEGREE BURS OF LOWER LIMBS				DUE TO, OR AS A CONSEQUENCE OF:	
8 buttocks					
(C) G.I. Bleeding due to Thrombocytopenia					
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
2. None					
20A. AUTOPSY? (Yes or No)				20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
Yes				Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, room, locality, street, office bldg., etc.)	
<input checked="" type="checkbox"/>				AT HOME	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	
102, CARLTON AVE. 1802				MARCH 5 72 9a	
21E. INJURY OCCURRED				21F. HOW DID INJURY OCCUR?	
While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>				ACCIDENTLY SAT ON A SPACE HEATER	
22. I certify that (this hospital) attended the deceased from MARCH 5, 1972 to APRIL 14, 1972					
that (I) (we) last saw the deceased alive on APRIL 14, 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
K. K. Pandya M.D.				APR 14, 72	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
K. K. PANDYA. M.D.				4940 Eastern Avenue Baltimore, Maryland 21224	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY	
Burial		4/21/72		Mt Calvary Cemetery	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
APR 24 1972		Robert E. Walker, M.D.		A Hilstead 1206 W North Ave	

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released for funeral home use. It must be signed by the medical examiner or his assistant. It shows: (1) An accident or injury, if the cause of death was determined; (2) A disease or condition, if the cause of death was determined; (3) A disease or condition, if the cause of death was determined; (4) A disease or condition, if the cause of death was determined; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

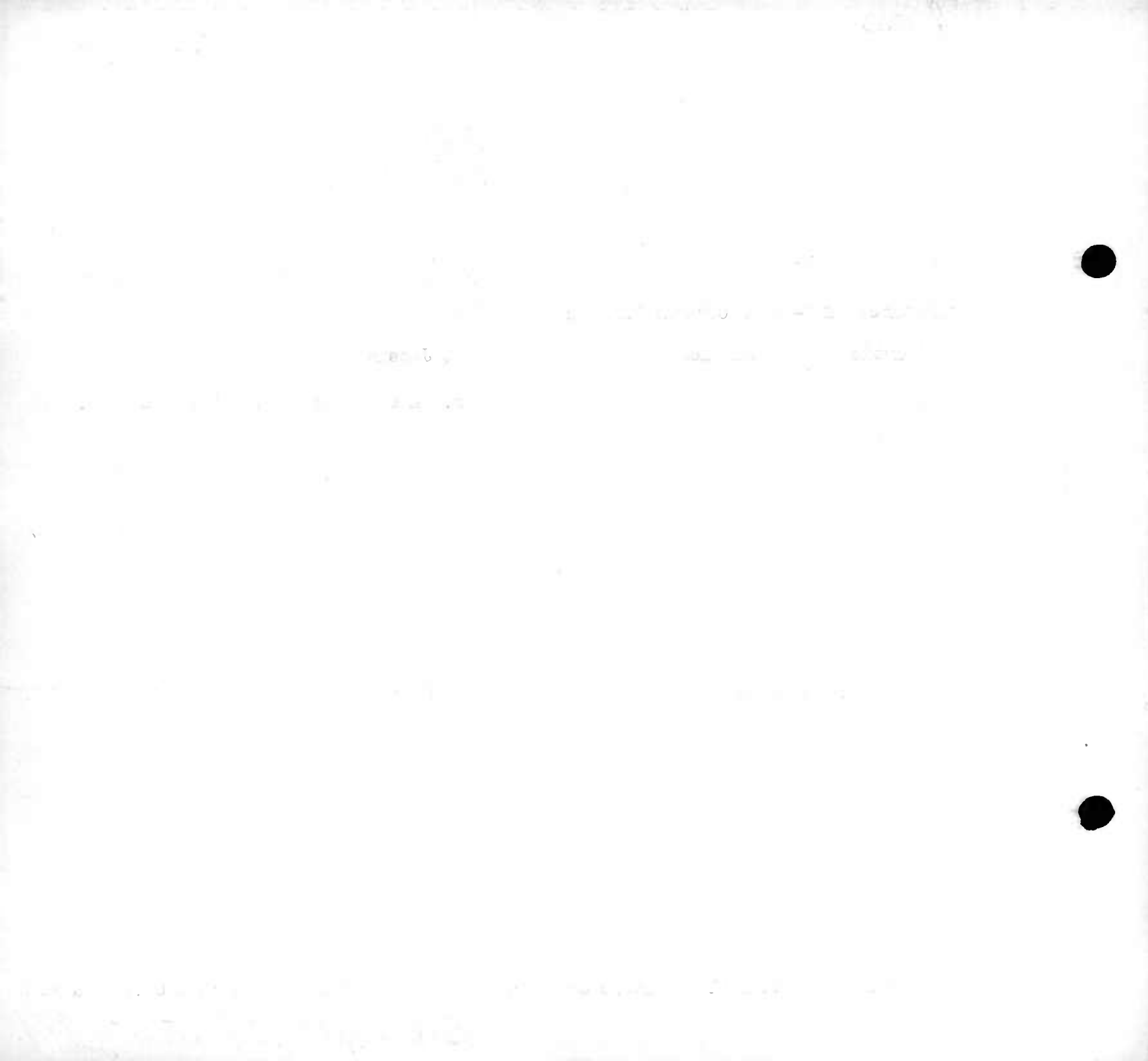


RECEIVED
JAN 10 1964
U.S. DEPT. OF AGRICULTURE
WASHINGTON, D.C.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

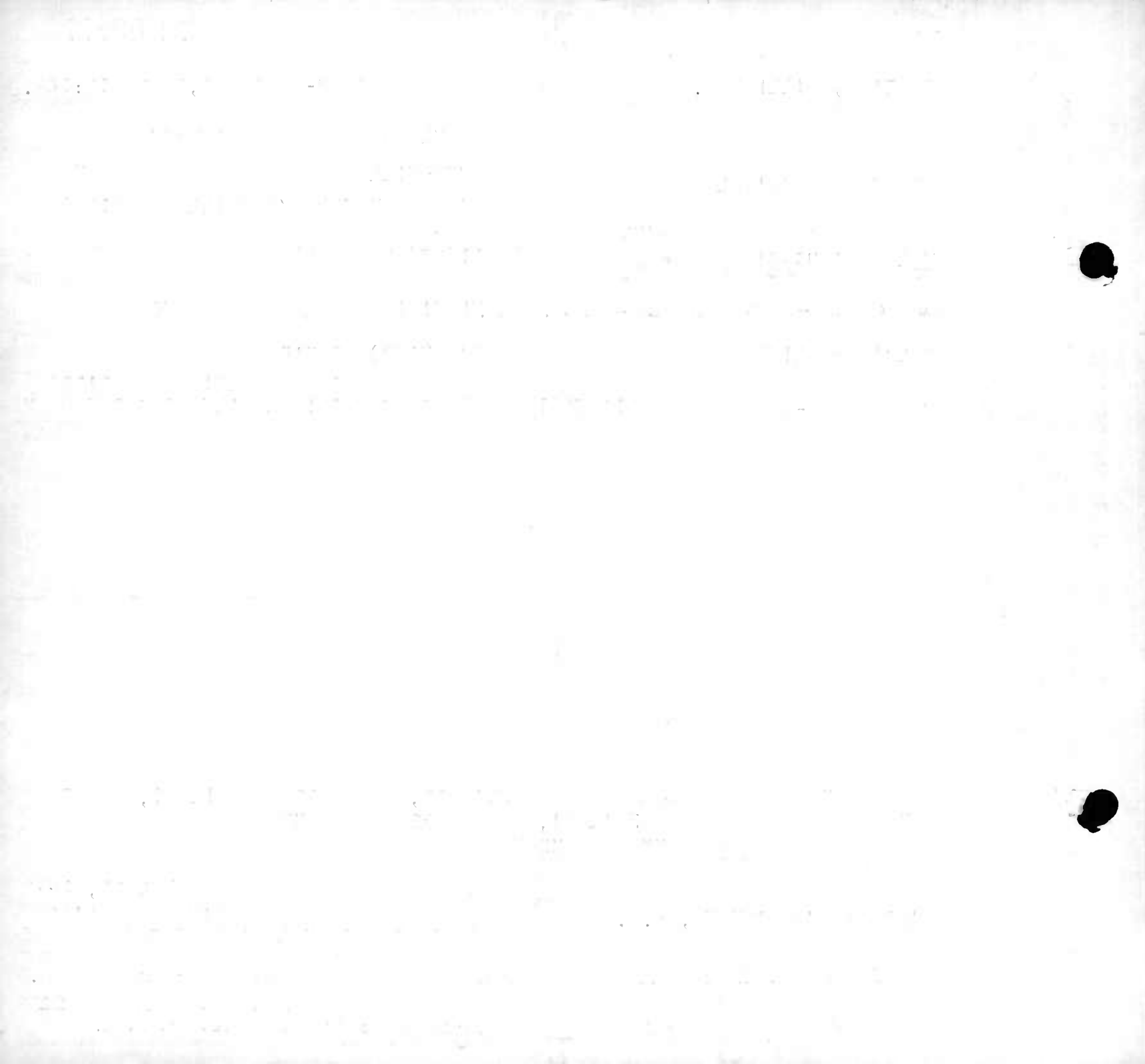
BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. <u>72 03876</u>
1. NAME OF DECEASED (Type or Print) <u>HAMMACK - WILLIAM</u>		2. DATE AND HOUR OF DEATH <u>4-20-72</u> <u>2:40 A.M.</u>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>BON SECOURS Hospital</u> <u>34</u>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MD.</u> B. COUNTY <u>2531</u>		
5. SEX <u>Male</u>	6. RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>01/16/23</u>	9. AGE (In years last birthday) <u>49</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Maintenance Man - Penn Central Railroad</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>W. VA.</u>
13. FATHER'S NAME <u>Brantie Hammack</u>		14. MOTHER'S MAIDEN NAME <u>Jessie (Boggs)</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u> <u>None</u>		16. SOCIAL SECURITY NO. <u>218-18-6273</u>		17. INFORMANT <u>Mrs. Nancy Kirts</u> ADDRESS <u>5111 Frederick Ave. 29</u>
18. <u>011-9</u> I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>CHF</u> <u>Pul. TB</u>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>hour</u> <u>month</u> <u>years</u>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) <u>(this hospital)</u> attended the deceased from <u>4-14</u> 19 <u>72</u> to <u>4-20</u> 19 <u>72</u> that (I) <u>(we)</u> last saw the deceased alive on <u>4-20-72</u> 19 <u>72</u> and that in (my) <u>(our)</u> opinion death occurred on the date and hour and from the causes stated above. (I) <u>(We)</u> <u>(did)</u> (did not) view the body after death.				
23A. SIGNATURE <u>Banditt</u>		23B. DATE SIGNED <u>4-20-72</u>		23C. PHYSICIAN'S NAME (Type) <u>BANDLTH</u>
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>4/22/1972</u>		24C. NAME of CEMETERY or CREMATORY <u>Saters Cemetery</u>
24D. LOCATION <u>Baltimore Balto. Co., Maryland</u>		25A. DATE REC'D BY HEALTH DEPT. <u>APR 24 1972</u>		
25B. NAME OF REGISTRAR <u>9-7-2000</u>		25C. FUNERAL DIRECTOR <u>8728 Liberty Road</u> ADDRESS <u>Liberty Rd.</u>		



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

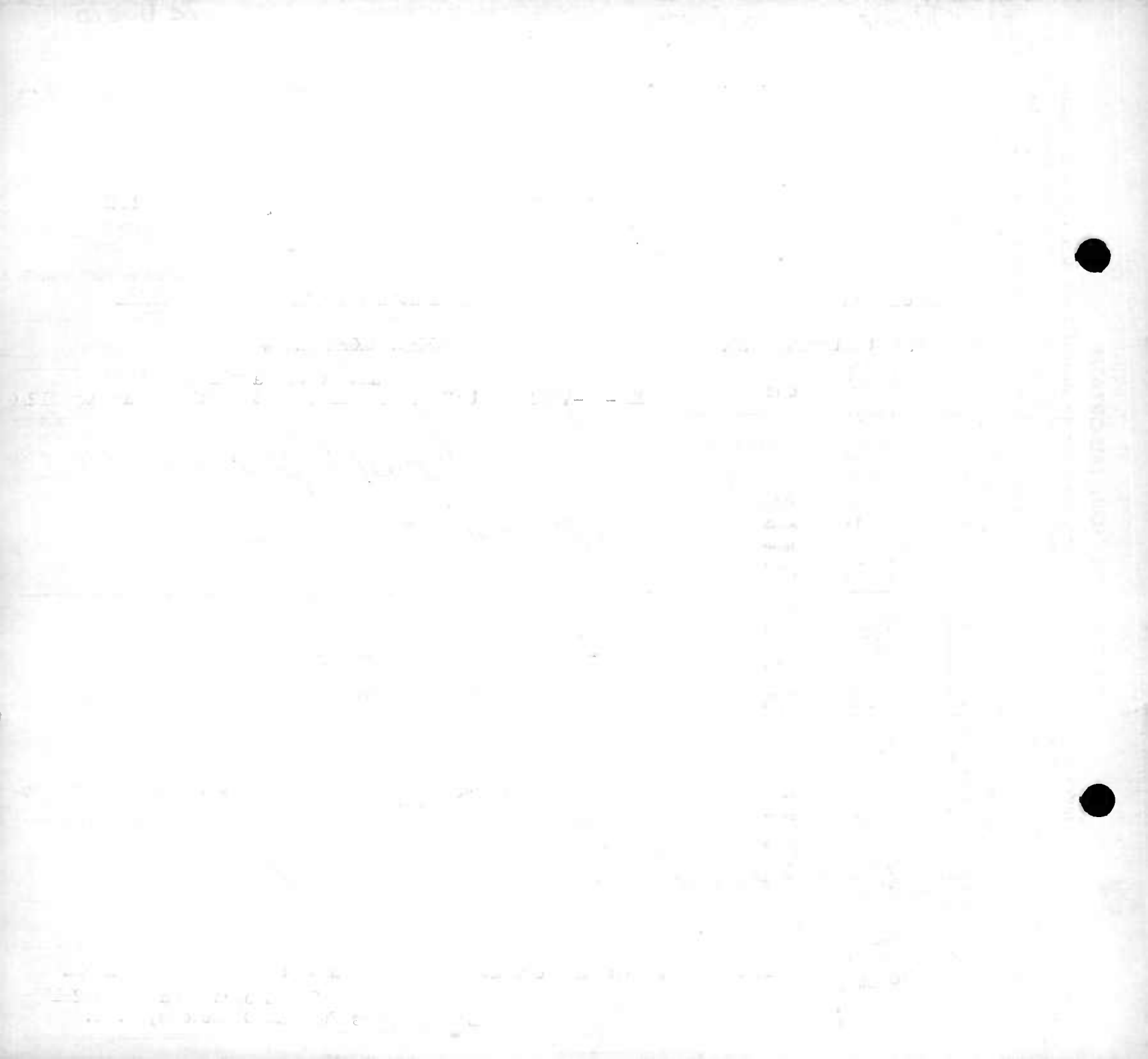
Baltimore City Health Department				CERTIFICATE OF DEATH		REG. NO. 72 03877	
7-626 72 03877				BIRTH NO.			
1. NAME OF DECEASED (Type or Print) FRAZIER, WILLIAM O.				2. DATE AND HOUR OF DEATH FRIDAY-APRIL 21, 1972 12:10A			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) ST AGNES HOSPITAL 40				A. STATE MARYLAND B. COUNTY CARROLL COUNTY 5600			
				C. CITY OR TOWN SYKESVILLE		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
				E. STREET AND NUMBER RT 34 BOX 584 SYKESVILLE MD 21784			
5. SEX MALE	6. RACE CAUCASIAN	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11/25/97	9. AGE (In years lost birthday) 74	If Under 1 Yr. Months: Days: Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Track Foreman - United Railway - Balto. Tran.				11. BIRTHPLACE (State or foreign country) VIRGINIA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME MELVIN FRAZIER				14. MOTHER'S MAIDEN NAME (JENKINS) BERTIE			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES WW-1				16. SOCIAL SECURITY NO. 213059410		17. INFORMANT RECORDS BALTIMORE MD 21229 ST AGNES HOSPITAL WILKENS & CATON AVE	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				Heart failure		8 days	
ANTECEDENT CAUSES				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				Arteriosclerotic Cardiovascular disease and old myocardial infarction			
				(B) DUE TO, OR AS A CONSEQUENCE OF:			
				(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				Strangulated hernia (inguinal)			
19A. DATE OF OPERATION 4-12-72		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED reduction & repair of hernia		20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (X) (this hospital) attended the deceased from APRIL 12, 1972 to APRIL 21, 1972 that (X) (we) lost saw the deceased alive on APRIL 21, 1972 and that in (XX) (our) opinion death occurred on the date and hour and from the causes stated above. (XX) (We) (did) (XXX) view the body after death.							
23A. SIGNATURE J. L. L. M. MUANGSOMBUT, M.D. JESADA MUANGSOMBUT				23B. DATE SIGNED APRIL 21, 1972			
23C. PHYSICIAN'S NAME (Typed) MUANGSOMBUT, M.D. JESADA MUANGSOMBUT				23D. ADDRESS ST AGNES HOSPITAL WILKENS & CATON AVE		BALTIMORE MD 21229	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4/24/1972		24C. NAME OF CEMETERY or CREMATORY Lake View Memorial Park		24D. LOCATION (City, town, or county) Sykesville Carroll Md.	
25A. DATE REC'D BY HEALTH DEPT. APR 24 1972		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR 8728 Liberty Road		ADDRESS 21133 Loring Byers Funeral Directors, P. A.	



FUNERAL DIRECTOR: IMPORTANT

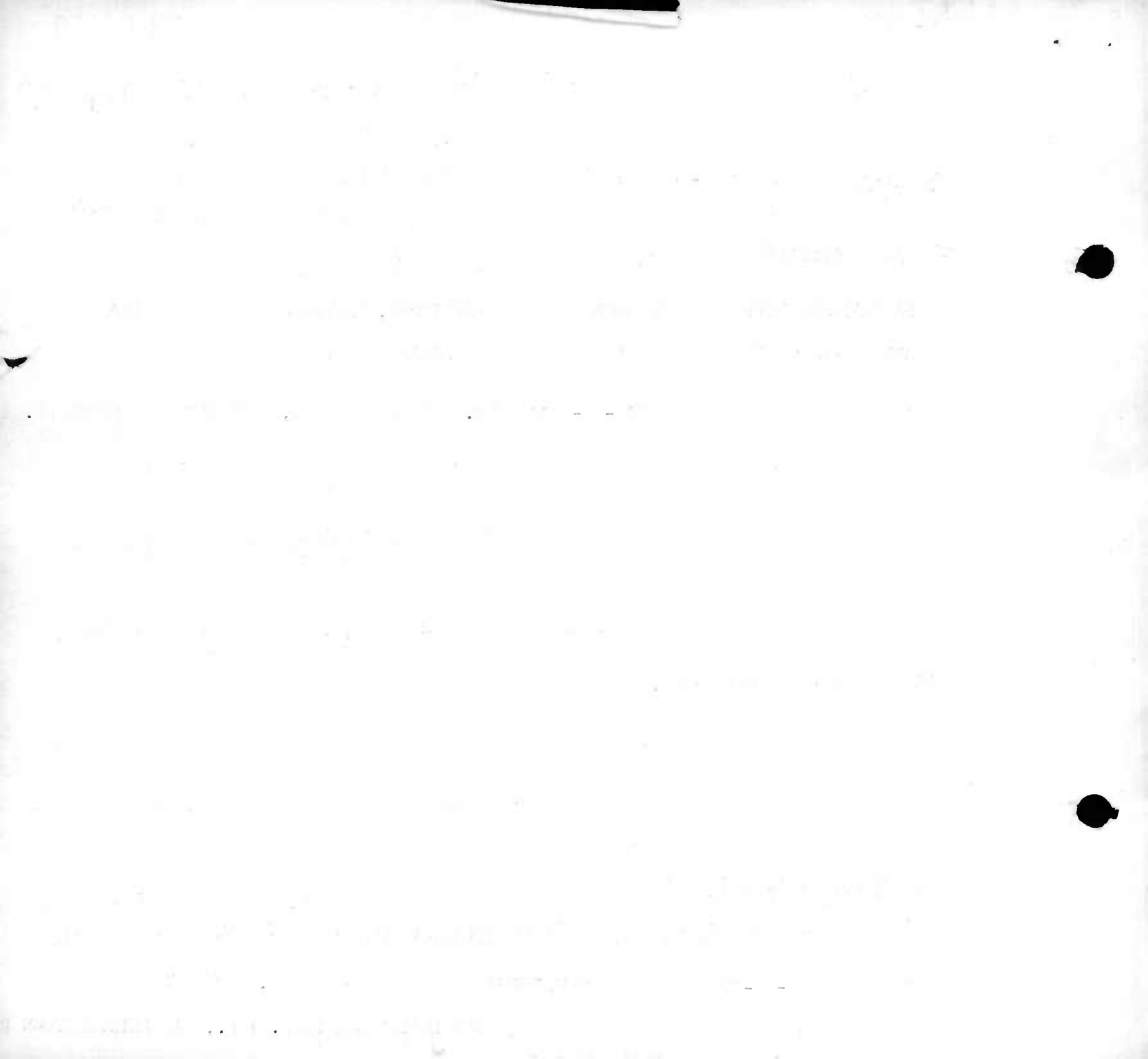
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 03878	
R-000 72 03878		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
RAO, Palem S.		4/20/72		12:40 p.m.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE		B. COUNTY	
33 The Johns Hopkins Hospital		Maryland		2755	
		C. CITY OR TOWN		D. INSIDE CITY LIMITS?	
		Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER			
		1190W Northern Parkway		21210	
5. SEX	6. RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. If Under 1 Yr. Months Days
Male	Cauc.	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9/5/25	46	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Medical Doctor				Visakhapatnam, India	
12. CITIZEN OF WHAT COUNTRY?		India			
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME			
P. MUDDUKRISH NAIAH		VEERA RAGHA VAMMA			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT	
No		None		Baltimore, Maryland	
		219-40-4332		SUMITRA RAO 1190 West Northern Parkway 21210	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH			
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
ANTECEDENT CAUSES		DUE TO, OR AS A CONSEQUENCE OF:			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) Hodgkin's disease			
		(C)			
II		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		4-18-4-20			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
2				Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
(Month) (Day) (Year) (Hour)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from		4-18 19 72 to 4-20 19 72			
that (I) (we) lost saw the deceased alive on		4-20 19 72 and that in (my) (our) opinion death occurred on the date			
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE		23B. DATE SIGNED			
Joseph P. Finizio M.D.					
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
Joseph P. Finizio		601 Broadwa Cr			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Cremation		4/21/1972		Loudon Park Crematory	
24D. LOCATION (City, town, or county)		24E. LOCATION (State)			
Baltimore		Maryland			
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
APR 24 1972		Palem S. RAO		8728 Liberty Road ADDRESS 21133	
				Loring Byers Funeral Directors, P. A.	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

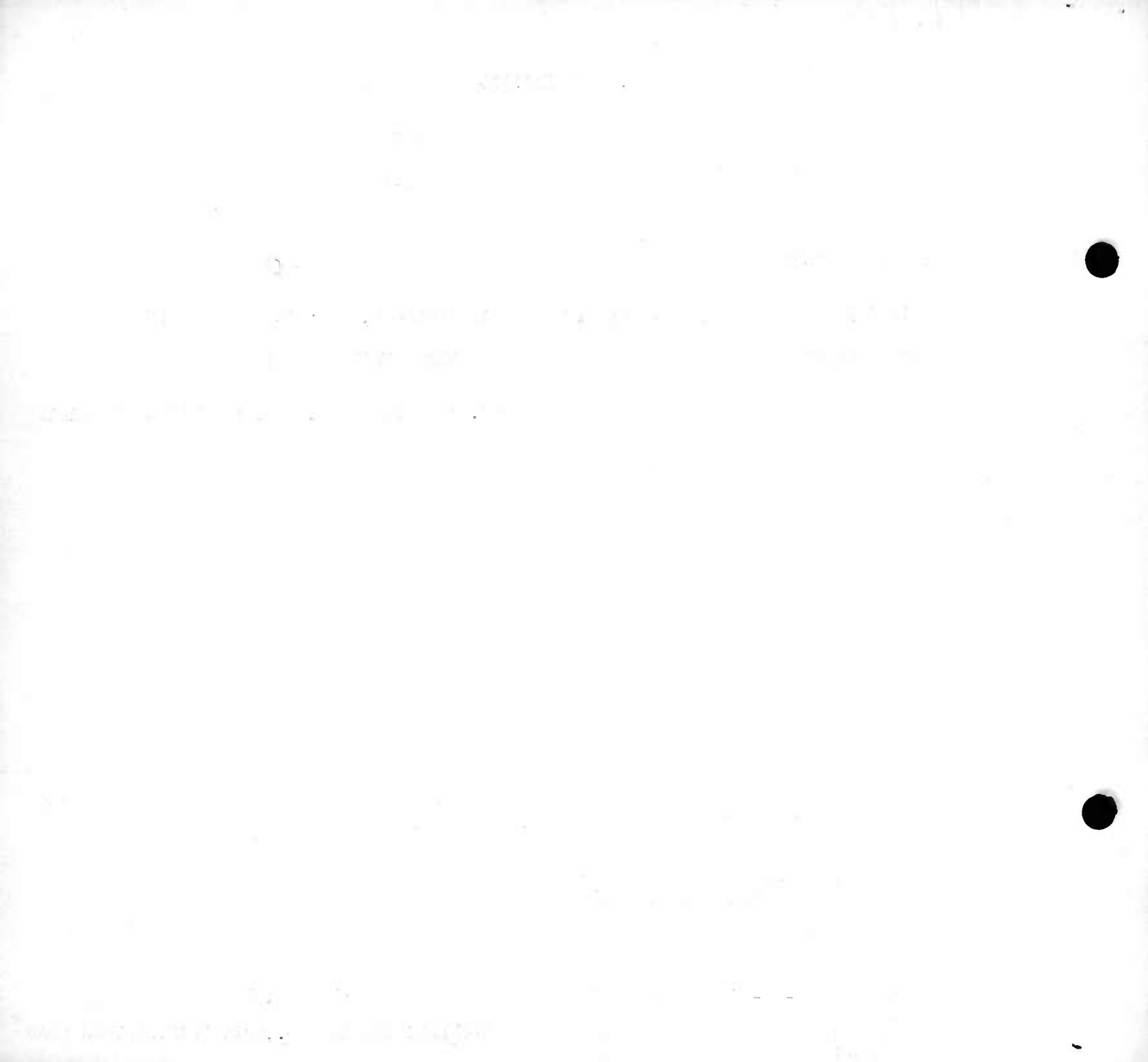
K-252		72 03879		BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		REG. NO. 72 03879	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) JENNIE KUSHNICK				2. DATE AND HOUR OF DEATH 18 APRIL 72 12 35 A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD						4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION SINAI HOSPITAL OF BALTIMORE, INC.						A. STATE MD.			
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)						B. COUNTY BALTO CITY		2730	
						C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
						E. STREET AND NUMBER 6807 PARK HEIGHTS AVE			
5. SEX FEMALE		6. RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 11-9-98		9. AGE (In years last birthday) 73	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10B. KIND OF BUSINESS OR INDUSTRY AT HOME		11. BIRTHPLACE (State or foreign country) BALTIMORE, MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME SAMUEL MOSKOWITZ				14. MOTHER'S MAIDEN NAME SARAH ?					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO				16. SOCIAL SECURITY NO. 216-46-4411		17. INFORMANT MR. NORMAN KUSHNICK, 7021 PHEASANT CROSS DR.			
18. 410.01 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshtenia, etc. It means the disease, injury or complication which caused death.) ACUTE MYOCARDIAL INFARCTION						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 hr.			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last (B) HYPERTENSIVE CARDIOVASC. DISEASE (C) _____						Years			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). Post OP - (R) Nephrectomy						4 days			
19A. DATE OF OPERATION 4-14-72		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED RENAL CALCULI		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from 12 APRIL 1972 to 18 APRIL 1972 that (I) (we) last saw the deceased alive on 18 APRIL 1972 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
23A. SIGNATURE Michael Schultz MD						23B. DATE SIGNED 18 APRIL 72			
23C. PHYSICIAN'S NAME (Type) SCHULTZ, MICHAEL M.D.						23D. ADDRESS SINAI HOSP. OF BALTO. INC			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 4-19-72		24C. NAME OF CEMETERY OR CREMATORY HEBREW FRIENDSHIP		24D. LOCATION (City, town, or county) (State) BALTIMORE, MARYLAND			
25A. DATE REC'D BY HEALTH DEPT. APR 24 1972		25B. NAME OF REGISTRAR Reverend J. J. ...		25C. FUNERAL DIRECTOR SOL LEVINSON & BROS. INC.		ADDRESS 6010 REISTERSTOWN RD			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

N-242 72 03880		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 03880	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		NICHELSON, ANNE XXXXXX		4/17/72 8:20 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				A. STATE	
42 Sinai Hospital of Baltimore Belvedere Av. at Greenspring				MARYLAND	
				C. CITY OR TOWN	
				BALTIMORE	
				D. INSIDE CITY LIMITS?	
				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER	
				4002 Pinkney Rd. #15	
5. SEX	6. RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
FEMALE	WHITE	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	11/27/11	60	LIBRARIAN
		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?
		BAR ASSOCIATION	X BALTIMORE, MARYLAND		USA
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
MAX AGETSTEIN			XXX YETTA ?		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		
NO					
			17. INFORMANT		
			MR. MAX NICHELSON, 4001 PINKNEY ROAD #21215		
			ADDRESS		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH			CAUSE OF DEATH		
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)			Respiratory failure -		
ANTECEDENT CAUSES			(A) IMMEDIATE CAUSE		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			DUE TO, OR AS A CONSEQUENCE OF:		
			Adenocarcinoma of Lung &		
			(B) DUE TO, OR AS A CONSEQUENCE OF:		
			with diffuse metastases		
			(C) and a pleural effusion		
			had Ca of colon operated 10 years ago		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
0 now					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from 3/14/72 to 4/17/72 and that (I) (we) last saw the deceased alive on 4/17/72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
H. LEVEQUE					
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
H. LEVEQUE				Sinai Hospital of Baltimore	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY	
BURIAL		4-19-72		AITZ CHAIM	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
APR 24 1972		J. E. ...		SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD	
				ADDRESS	



MAK

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

REG. NO.

72 03881

BIRTH NO.

1. NAME OF DECEASED

(Type or Print)

KING, EMILY

2. DATE AND HOUR OF DEATH

APRIL 18, 1972 7:10 P. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

ST AGNES HOSPITAL

4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission)

A. STATE

B. COUNTY

MARYLAND

C. CITY OR TOWN

BALTIMORE

D. INSIDE CITY LIMITS?

YES ☒NO ☐

E. STREET AND NUMBER

448 SOUTH AUGUSTA AVENUE

21229

5. SEX

FEMALE

6. RACE

CAUCASIAN

7. MARRIED ☐NEVER MARRIED ☐WIDOWED ☒DIVORCED ☐

8. DATE OF BIRTH

7/23/90

9. AGE (In years)

(last birthday) 81

If Under 1 Yr.

Months Days

If Under 24 Hrs.

Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

HOUSEWIFE

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

PENNSYLVANIA

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

P

14. MOTHER'S MAIDEN NAME

ADELINE

P

15. Was Deceased Ever in U. S. Armed Forces?

(Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

BALTIMORE MARYLAND

ADDRESS

21229

ST AGNES HOSPITAL CATON & WILKENS AVE

18. 412.4

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

ASCVD

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At Work ☐Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (X) (this hospital) attended the deceased from APRIL 15, 1972 to APRIL 18, 1972 that (X) (we) last saw the deceased alive on APRIL 18, 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (did not) view the body after death.

23A. SIGNATURE

23C. PHYSICIAN'S NAME (Type)

Attending Phys. ☐Med. Director ☐Staff Phys. ☒

23B. DATE SIGNED

23D. ADDRESS

BALTIMORE MARYLAND 21229

ST AGNES HOSPITAL CATON & WILKENS AVE

24A. BURIAL CREMATION, REMOVAL (Specify)

Cremation

24B. DATE

4/21/1972

24C. NAME OF CEMETERY or CREMATORY

Loudon Park

24D. LOCATION

(City, town, or county)

Baltimore, Maryland

(State)

25A. DATE REC'D BY HEALTH DEPT.

APR 24 1972

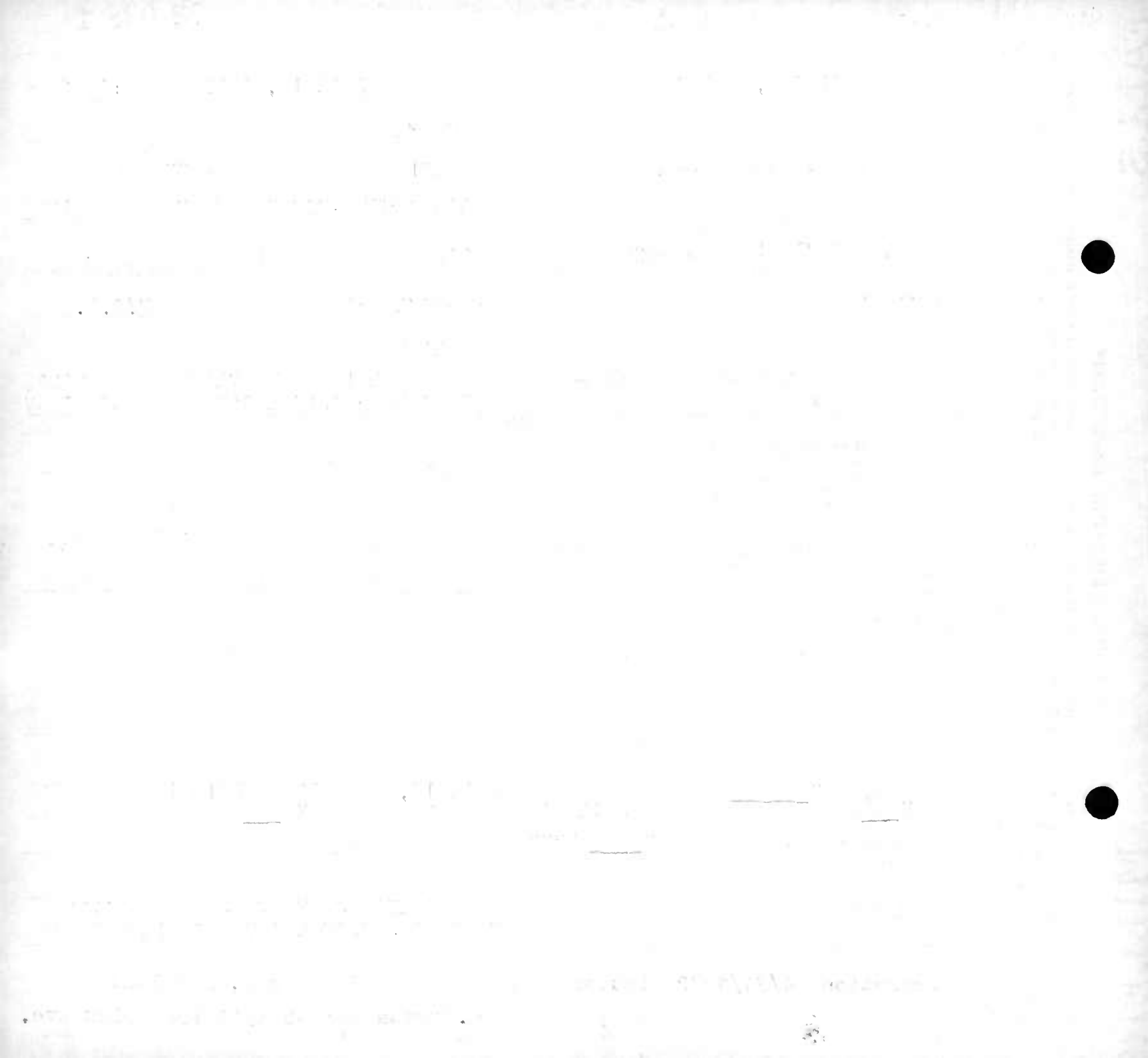
25B. NAME OF REGISTRAR

Robert E. J. J. J.

25C. FUNERAL DIRECTOR

G. Truman Schwab 3512 Frederick Ave.

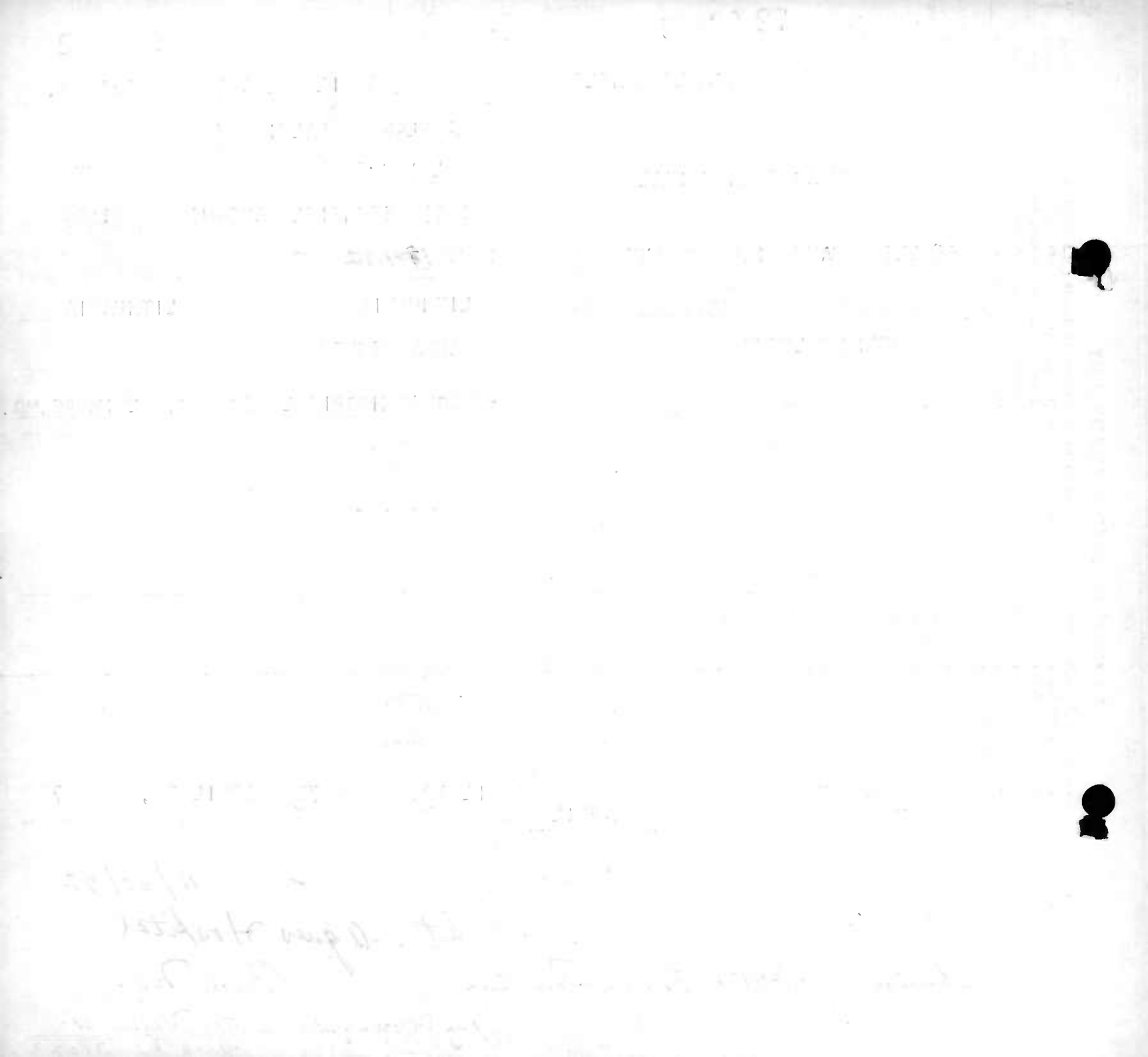
ADDRESS



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-300 72 03882		BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		REG. NO. 72 03882	
1. NAME OF DECEASED (Type or Print) BUDA, MAGDALENA HELEN				2. DATE AND HOUR OF DEATH APRIL 20, 1972 3:30 P. M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 40 ST AGNES HOSPITAL				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER 1017 BEECHFIELD AVENUE 21229			
5. SEX FEMALE	6. RACE CAUCASIAN	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/14/1922	9. AGE (In years last birthday) 89	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Stamatis		
11. BIRTHPLACE (State or foreign country) LITHUANIA			12. CITIZEN OF WHAT COUNTRY? LITHUANIA				
13. FATHER'S NAME ANTHONY LOTUS				14. MOTHER'S MAIDEN NAME ANNA MESKES			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 215-50-4464		17. INFORMANT ST AGNES HOSPITAL RECORDS, BALTIMORE, MD.			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. 427.01 CAUSE OF DEATH Respiratory failure C.H.F.				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (X) (this hospital) attended the deceased from APRIL 19, 1972 to APRIL 20, 1972 that (X) (we) last saw the deceased alive on APRIL 20, 1972 and that in (X) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (did not) view the body after death.							
23A. SIGNATURE E. Romero M.D.				23B. DATE SIGNED 4/20/72		23C. PHYSICIAN'S NAME (Typed) EDUARDO G. ROMERO, M.D.	
24A. BURIAL CREMATION, REMOVAL (Specify) burial		24B. DATE 4/24/72		24C. NAME OF CEMETERY or CREMATORY Linden Park Cem.		24D. LOCATION (City, town, or county) (State) Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT. APR 24 1972		25B. NAME OF REGISTRAR Robert E. Taylor, Jr.		25C. FUNERAL DIRECTOR John J. Connelley, Jr.		ADDRESS 901 Haller St.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

H-630 72 03883				BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		REG. NO. 72 03883	
1. NAME OF DECEASED (Type or Print) MISS ETHEL HARRODY				2. DATE AND HOUR OF DEATH 20 Apr. 72 5:30 P.M.					
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MD. B. COUNTY Balti					
FULL NAME OF HOSPITAL OR INSTITUTION Provident Hospital				IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION 2600 Liberty Heights Avenue		C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
Baltimore, Maryland 21215				E. STREET AND NUMBER 2462 Druid Hill Avenue					
5. SEX F	6. RACE N	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1/5/11	9. AGE (In years last birthday) 61	10. Under 1 Yr. Months Days		11. Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unemployed				10B. KIND OF BUSINESS OR INDUSTRY		11. STATE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. AA.	
13. FATHER'S NAME James Harrody				14. MOTHER'S MAIDEN NAME Stella					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. 311-18-8358		17. INFORMANT Mrs. Lillian Vickers (Sister)			
				ADDRESS 1607 Vincent		Ct.			
18. 430.91 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Cardiorespirator failure				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:					
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) Subarachnoid Haemorrhage DUE TO, OR AS A CONSEQUENCE OF:					
				(C)					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				ASCV D.					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR?		(If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (1) (this hospital) attended the deceased from 04-17 1972 to 04-20 1972 that (1) (we) last saw the deceased alive on 04-20 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.									
23A. SIGNATURE R. Rupak Mitra				MD DEGREE		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 04-20-72	
23C. PHYSICIAN'S NAME (Type) DR RUPAK MITRA				MD DEGREE		23D. ADDRESS Provident Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4/25/72		24C. NAME OF CEMETERY OR CREMATORY New Cathedral		24D. LOCATION (City, town, or county) (State) Baltimore, Md			
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR Adolphus Halstead		ADDRESS 1206 W North Ave			

1997

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

W-160		72 03884		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 03884	
BIRTH NO.				1. NAME OF DECEASED (Type or Print) CHAUNCEY A. WEAVER			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				2. DATE AND HOUR OF DEATH 4/20/72 9:40 P.M.			
FULL NAME OF HOSPITAL OR INSTITUTION South Baltimore General		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY 2302		C. CITY OR TOWN Baltimore 21230	
5. SEX Male		6. RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH July 18, 1915	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Drawbridge Op.		10B. KIND OF BUSINESS OR INDUSTRY Railroad		9. AGE (in years lost birthday) 56		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Weaver				14. MOTHER'S MAIDEN NAME Bessie			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes WW 2		16. SOCIAL SECURITY NO. 213 18 8491		17. INFORMANT Frank Sarro		ADDRESS 113 5th Ave. S.E. Glen Burnie, Maryland	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) 4/10/72 I Myocardial Infarction				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 DAYS			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Atherosclerosis				DUE TO, OR AS A CONSEQUENCE OF: YEARS			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).							
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 4/12/72 19 to 4/20/72 19 that (I) (we) lost saw the deceased alive on 4/20/72 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Edmund P. Garvey				23B. DATE SIGNED 4/20/72		23C. PHYSICIAN'S NAME (Type) GARVEY	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4-25-72		24C. NAME of CEMETERY or CREMATORY Gettysburg National Cemetery		24D. LOCATION (City, town, or county) (State) Gettysburg, Pennsylvania	
25A. DATE REC'D BY HEALTH DEPT. APR 24 1972		25B. NAME OF REGISTRAR Valerie E. [Signature]		25C. FUNERAL DIRECTOR M. J. Gully Funeral Home			

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				CERTIFICATE OF DEATH		REG. NO. <u>72 03885</u>	
BIRTH NO. <u>B-600</u> <u>72 03885</u>				1. NAME OF DECEASED (Type or Print) <u>BAHR, JOSEPHINE D.</u>		2. DATE AND HOUR OF DEATH <u>4 20 72</u> <u>11:02 PM</u>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>ST AGNES HOSPITAL</u> <u>BALTIMORE, MARYLAND</u>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>2541</u> C. CITY OR TOWN <u>BALTIMORE</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>470 YALE AVE</u>			
5. SEX <u>FEMALE</u>	6. RACE <u>CAUCASIAN</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2 11 12 15</u>		9. AGE (In years last birthday) <u>57</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HSWF</u>			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>PA.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>
13. FATHER'S NAME <u>John Casey</u>				14. MOTHER'S MAIDEN NAME <u>Margaret Sullivan</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>			16. SOCIAL SECURITY NO.		17. INFORMANT <u>WILKENS & CATON AVES.</u> <u>ST AGNES HOSP., BALTO., MD.</u>		
18. <u>162.1 1 + 303.2</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <u>BILATERAL PNEUMONIA.</u> <u>ATRIAL FIBRILLATION.</u> <u>BRONCHOGENIC CARCINOMA Rt Lung.</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>CHRONIC ALCOHOLISM.</u> II <u>ALCOHOLIC ENCEPHALOPATHY</u>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>100 days.</u>			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).							
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>NO</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indify medical examined)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>3/9/1972</u> to <u>4 20 1972</u> that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>4/20/1972</u> and that <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) (did) <input checked="" type="checkbox"/> view the body after death.							
23A. SIGNATURE <u>HARJIT SINGH</u>				23B. DATE SIGNED <u>4/20/72</u>		23C. PHYSICIAN'S NAME (Type) <u>HARJIT SINGH M.D.</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>4-24-1972</u>		24C. NAME of CEMETERY or CREMATORY <u>Loudon Park Cemetery</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>APR 24 1972</u>		25B. NAME OF REGISTRAR <u>Robert J. Hub...</u>		25C. FUNERAL DIRECTOR <u>Howard H. Hubbard</u>			
				ADDRESS <u>4107 Wilkens Ave. 21229</u>			

1980-1981

Page 1

1980-1981

1980-1981

1980-1981

1980-1981

1980-1981

1980-1981

1980-1981

1980-1981

1980-1981

1980-1981

1980-1981

1980-1981

1980-1981

1980-1981

1980-1981

1980-1981

1980-1981

1980-1981

1980-1981

1980-1981

1980-1981

1980-1981

1980-1981

1980-1981

1980-1981

1980-1981

1980-1981

1980-1981

1980-1981

1980-1981

1980-1981

1980-1981

1980-1981

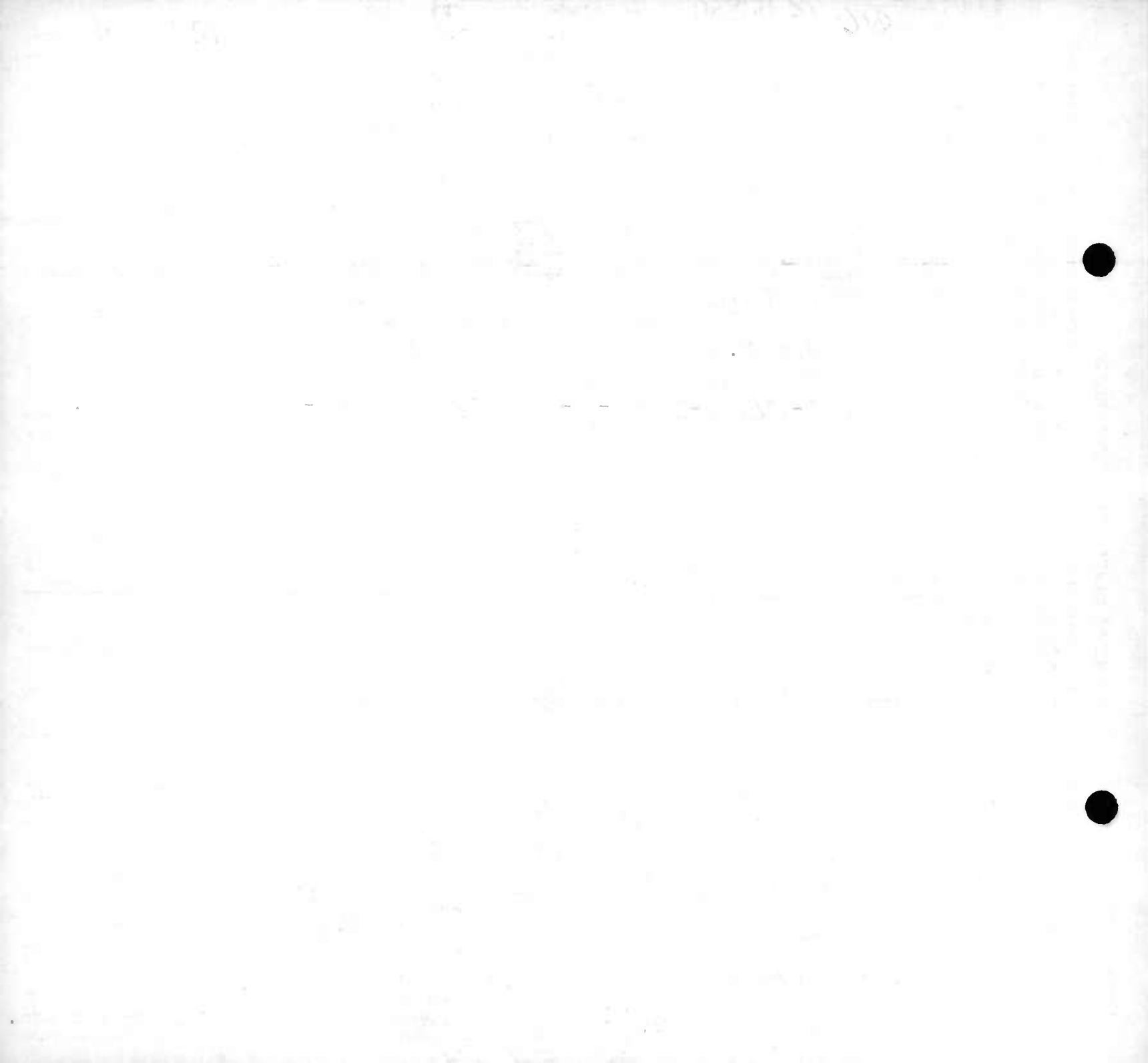
1980-1981

1980-1981

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

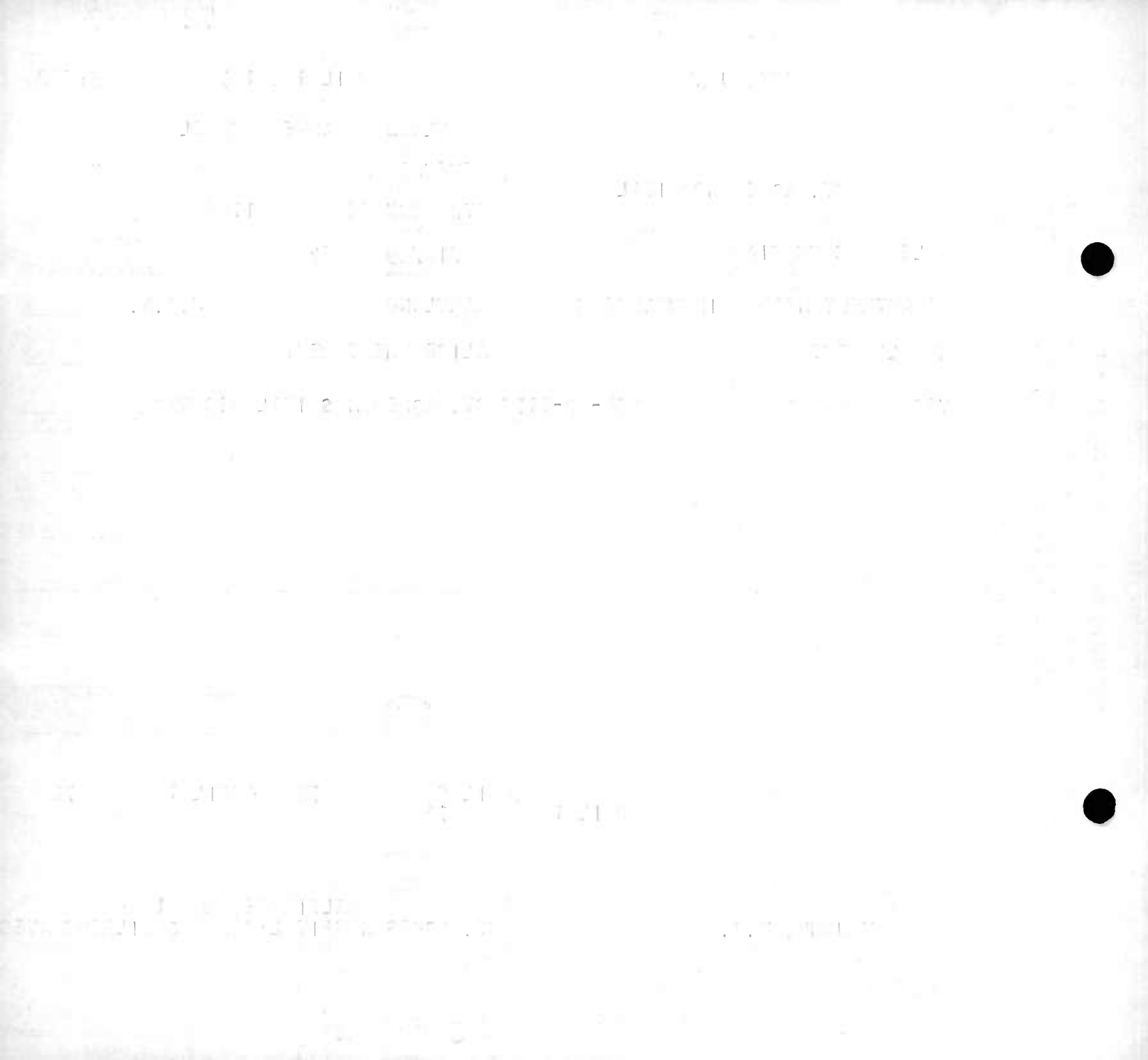
BIRTH NO.				BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 03886			
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH							
FRANK SIEGFRIED				APRIL 20 - 72				A M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institutions residence before admission)							
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				A. STATE B. COUNTY							
44 UNION MEMORIAL HOSP.				MARIAND				2748			
				C. CITY OR TOWN				D. INSIDE CITY LIMITS?			
				BALTIMORE				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
				E. STREET AND NUMBER							
				1127 GLENEAGLE ROAD							
5. SEX		6. RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday)		10. Under 1 Yr. Months Days	
Male		White		WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		01-04-1904		68			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
UNEMPLOYED Retired								Tennessee		AMERICAN	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME							
John D. Siegfried				Sleigh							
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.				17. INFORMANT ADDRESS			
Yes				1923-27/1932-36				213-05-5626 Linda Ogletree-1127 Gleneagle Rd.			
18. CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				(A) IMMEDIATE CAUSE				RESPIRATORY FAILURE			
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				DUE TO, OR AS A CONSEQUENCE OF:							
ANTECEDENT CAUSES				(B)				ARTERIOSCLEROTIC VASCULAR DISEASE			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				DUE TO, OR AS A CONSEQUENCE OF:							
(C)											
II											
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).											
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
1-4-03-1972		gastroenter both feet. Amputation. (X) (B) AKC									
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR?		(If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?							
1 Month 1 Day 1 Year 1 Hour		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>									
22. I certify that (i) (this hospital) attended the deceased from 2-29-72 to 4-20-72											
that (i) (we) lost saw the deceased alive on APRIL 19 1972 and that in (my) (our) opinion death occurred on the date											
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.											
23A. SIGNATURE				23B. DATE SIGNED							
A. Higuera				APRIL 20-72							
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS							
MIGUEL F. SCHEEL - INTERN				UNION MEMORIAL HOSPITAL							
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)					
Burial		4/24/72		Moreland Memorial Park		Baltimore, Maryland					
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS					
APR 24 1972		Robert E. Taylor, M.D.		Denoyan Funeral Home		3818 Roland Ave.					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

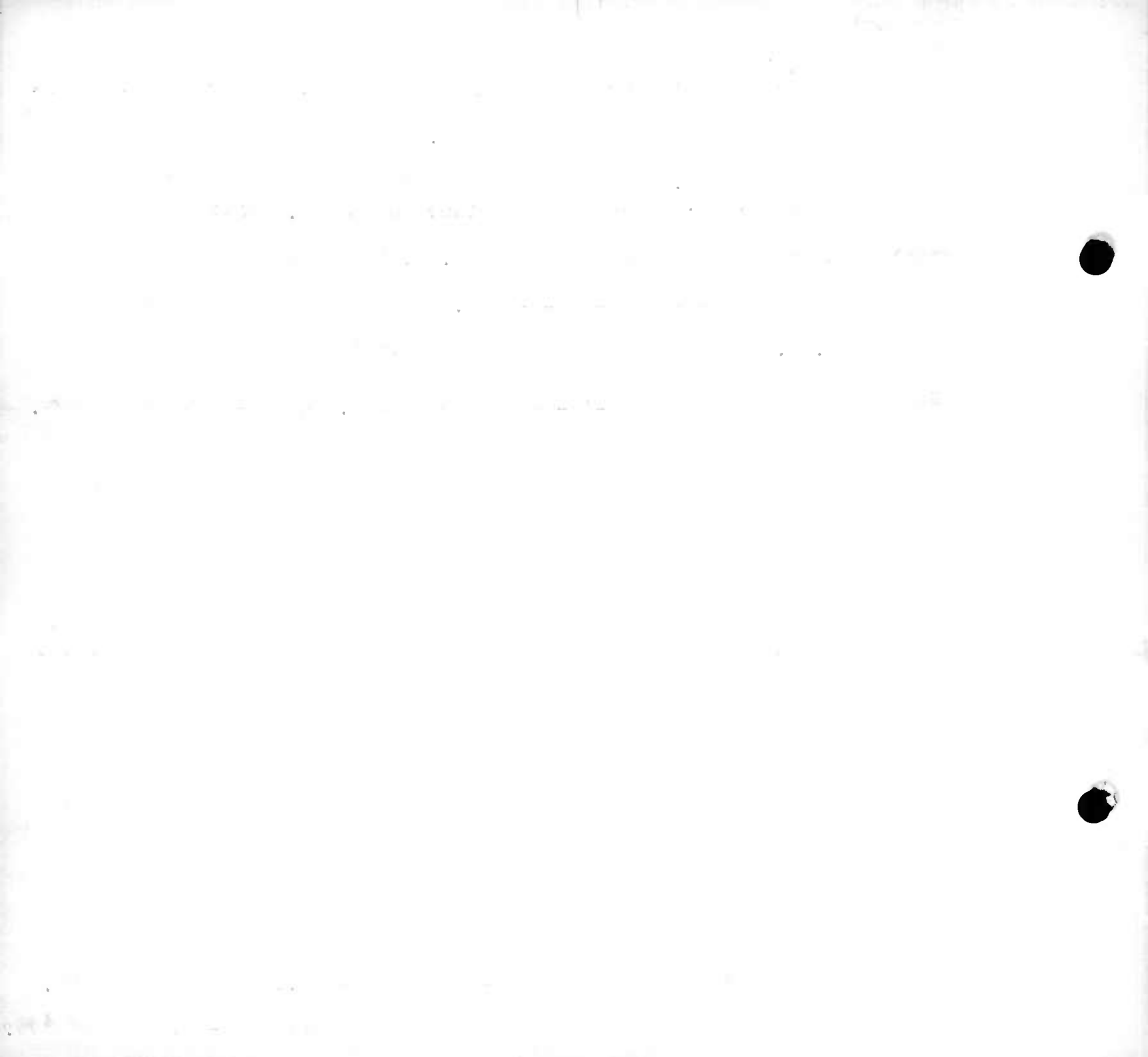
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>72 03887</u>	
<div style="display: flex; justify-content: space-between;"> <u>W-230</u> <u>72 03887</u> CERTIFICATE OF DEATH </div>					
1. NAME OF DECEASED (Type or Print) <u>WEST, JOHN T</u>			2. DATE AND HOUR OF DEATH <u>APRIL 18, 1972</u> <u>5:50P.M.</u>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>40 ST. AGNES HOSPITAL</u>			4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>ANNE ARUNDEL</u> <u>5200</u>		
			C. CITY OR TOWN <u>SEVERNA PARK</u>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
			E. STREET AND NUMBER <u>RT#2 BOX 66 21146</u>		
5. SEX <u>MALE</u>	6. RACE <u>CAUCASIAN</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>08/12/09</u>	9. AGE (in years last birthday) <u>62</u>	10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>DEPARTMENT HEAD</u>			10B. KIND OF BUSINESS OR INDUSTRY <u>INSURANCE CO</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>					
13. FATHER'S NAME <u>HAROLD WEST</u>			14. MOTHER'S MAIDEN NAME <u>ALICE WHEAT WEST</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>YES</u> <u>WW 2</u>			16. SOCIAL SECURITY NO. <u>254-09-1175</u>		17. INFORMANT <u>ST. AGNES HOSPITAL RECORDS</u>
18. <u>204.1</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>WIDESPREAD METASTASES</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>CHRONIC LYMPHO CYTIC LEUKAEMIA.</u>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY (Yes or No) <u>YES</u>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>YES</u>					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR (if in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR	
22. I certify that (I) (this hospital) attended the deceased from <u>APRIL 5</u> 19 <u>72</u> to <u>APRIL 18</u> 19 <u>72</u> that (I) (we) last saw the deceased alive on <u>APRIL 18</u> 19 <u>72</u> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Michael J. On</u>				23B. DATE SIGNED <u>4/19/72</u>	
23C. PHYSICIAN'S NAME (Type) <u>M. JOHN, M.D.</u>				23D. ADDRESS <u>BALTIMORE, MD 21229</u> <u>ST. AGNES HOSPITAL; CATON & WILKENS AVES</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>4/22/72</u>		24C. NAME OF CEMETERY or CREMATORY <u>Family Burial</u>	
24D. LOCATION (City, town, or county) (State) <u>Severna Park, Md 21146</u>					
25A. DATE REC'D BY HEALTH DEPT. <u>APR 24 1972</u>		25B. NAME OF REGISTRAR <u>Robert E. Fisher, M.D.</u>		25C. FUNERAL DIRECTOR <u>Robert S. Bernanos, Severna Park, Md.</u>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>72 03888</u>	
<div style="font-size: 2em; font-weight: bold;">S-158</div> <div style="font-size: 1.5em; font-weight: bold;">72 03888</div>		<div style="font-size: 1.5em; font-weight: bold;">CERTIFICATE OF DEATH</div>			
BIRTH NO. <u>72 03888</u> 1. NAME OF DECEASED (Type or Print) Sarah Elizabeth Spann		2. DATE AND HOUR OF DEATH April 19, 1972 3:15 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <div style="font-size: 1.5em; font-weight: bold;">00</div> 1002 Union Ave. Baltimore, Md. 21211		4. USUAL RESIDENCE (Where deceased lived, If institution residence before admission) A. STATE Md. B. COUNTY 1307 C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 1002 Union Ave. 21211			
5. SEX Female 6. RACE White 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 15, 1886 9. AGE (In years last birthday) 85 If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired 10B. KIND OF BUSINESS OR INDUSTRY - - - - -		11. BIRTHPLACE (State or foreign country) Md. 12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Jos. H. Esham		14. MOTHER'S MAIDEN NAME Powell			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 216-05-5465		17. INFORMANT ADDRESS Virginia E. Doster - 1002 Union Ave.	
18. 437.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic Vascular Disease ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) slowing the UNDERLYING CONDITION lost.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Arteriosclerotic Vascular Disease (B) DUE TO, OR AS A CONSEQUENCE OF: (C)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 8 years	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). Cerebral Vascular Insuff		5 years			
19A. DATE OF OPERATION 0 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20A. AUTOPSY? (Yes or No) 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from July 19 1968 to April 19 1972 that (I) (we) last saw the deceased alive on April 17 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Sheldon Goldgeier 23C. PHYSICIAN'S NAME (Type) SHELDON GOLDGEIER		23B. DATE SIGNED April 20 '72 Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23D. ADDRESS 848 W 36 ST	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4/22/72		24C. NAME OF CEMETERY OR CREMATORY New Cathedral Cemetery	
24D. LOCATION (City, town, or county) Balto.,		(State) Md.			
25A. DATE REC'D BY HEALTH DEPT. APR 24 1972		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR ADDRESS Donovan Funeral Home - 3818 Roland Ave.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

K-400 72 03889		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 72 03889	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) IRENE Kelly		2. DATE AND HOUR OF DEATH 4-21-72 4pm	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY 2804 Edmondson Ave. #28			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) MT. SINAI Nursing Home 4613 Park Heights Ave. #1215		C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX F		6. RACE N		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		8. DATE OF BIRTH 8-10-1900	
				9. AGE (In years last birthday) 71	
				11. BIRTHPLACE (State or foreign country)	
				12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME James Riky		14. MOTHER'S MAIDEN NAME (UNKNOWN)			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 129-90-97834		17. INFORMANT ADDRESS	
18. 5-90.11 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH I (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Hypertensive C-V Disease ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Chronic Uremia II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). Pyelonephritis		CAUSE OF DEATH Hypertensive C-V Disease (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Chronic Uremia (B) DUE TO, OR AS A CONSEQUENCE OF: Pyelonephritis (C) DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
MEDICAL CERTIFICATION					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Sept 4 19 71 to April 21 19 72 that (I) (we) last saw the deceased alive on April 14 19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Louis T. Lavy M.D.				23B. DATE SIGNED 4-21-72	
23C. PHYSICIAN'S NAME (Type) LOUIS T. LAVY				23D. ADDRESS 3502 W. Rogers Ave Baltimore	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE 4-26-72		24C. NAME OF CEMETERY or CREMATORY Mt. Auburn	
24D. LOCATION (City, town, or county) (State) Baltimore Md.					
25A. DATE REC'D BY HEALTH DEPT. APR 24 1972		25B. NAME OF REGISTRAR Rebecca E. J. ...		25C. FUNERAL DIRECTOR ADDRESS 2700 Edmondson Ave	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

M-600 72 03890		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 03890	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>MURRAY Edith</i>		2. DATE AND HOUR OF DEATH <i>4/20/1972 12:50 P.M.</i>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>MD</i> B. COUNTY <i>1511</i>		C. CITY OR TOWN <i>BALTIMORE</i> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
FULL NAME OF HOSPITAL OR INSTITUTION <i>42 Sinai Hospital</i>		E. STREET AND NUMBER <i>3703 1/2 Columbus Dr.</i>			
5. SEX <i>FE</i>	6. RACE <i>NEGRO</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>9-29-1895</i>	9. AGE (in years last birthday) <i>76</i>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Home maker</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>at home</i>		11. BIRTHPLACE (State or foreign country) <i>Calvert County</i>	
12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		13. FATHER'S NAME <i>GEORGE WALLACE</i>		14. MOTHER'S MAIDEN NAME <i>Emily PATTERSON</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>no</i>		16. SOCIAL SECURITY NO.		17. INFORMANT <i>Lucille Townsend</i> ADDRESS <i>3703 1/2 Columbus Dr.</i>	
18. <i>174 X I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Plumal suffusion</i> (B) <i>Ca of Breast</i> (C) <i>Plumal metastase</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>1 week</i> <i>5 yrs.</i>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)	
21C. WHERE DID INJURY OCCUR? (if in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I certify that (1) (this hospital) attended the deceased from <i>4/17/72</i> to <i>4/20/72</i> and that (2) (we) lost saw the deceased alive on <i>4/20/72</i> and that (3) (our) opinion death occurred on the date and hour and from the causes stated above. (If (We) (did) (did not) view the body after death.			
23A. SIGNATURE <i>Robert E. Taylor</i>		23B. DATE SIGNED <i>4/20/72</i>		23C. PHYSICIAN'S NAME (Type)	
23D. ADDRESS		23E. FUNERAL DIRECTOR <i>Robert E. Taylor</i>		23F. ADDRESS <i>635 N. Calmar St</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>BURIAL</i>		24B. DATE <i>4/27/72</i>		24C. NAME OF CEMETERY or CREMATORY <i>BALTO. NATIONAL</i>	
24D. LOCATION (City, town, or county) (State) <i>BALTO MD</i>		24E. DATE REC'D BY HEALTH DEPT. <i>APR 24 1972</i>		24F. NAME OF REGISTRAR <i>Robert E. Taylor</i>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO.	
S-530		72 03891		72 03891	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) CLARENCE J. SMITH		2. DATE AND HOUR OF DEATH 4/21/72 12 48 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MD. B. COUNTY BALT.		5. CITY OR TOWN Catonsville D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
FULL NAME OF HOSPITAL OR INSTITUTION 34 BON SECOURS HOSPITAL		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		E. STREET AND NUMBER 408 Ingleside Ave. 21228	
5. SEX M	6. RACE Can.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 1/29/98	9. AGE (in years last birthday) 74	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Electrical Engineer		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MD	
12. CITIZEN OF WHAT COUNTRY USA		13. FATHER'S NAME TRA SMITH		14. MOTHER'S MAIDEN NAME BLANCHE PAREGORY	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 216-10-7304A		17. INFORMANT Miss Patricia Jensen, Chart ADDRESS 408 Ingleside Avenue	
18. 4/21/72 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Pneumonia + edema of left lung. (B) Consecutive Heart Failure DUE TO, OR AS A CONSEQUENCE OF: (C) Arteriosclerosis of Heart.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 days 4 days years	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		Resection of right lung for bronchiectasis + carcinoma.		4 days	
19A. DATE OF OPERATION 4-17-72		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Rt. Lung Lesions		20A. AUTOPSY (Yes or No) Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from _____ 19____ to _____ 19____ that (I) (we) last saw the deceased alive on _____ 19____ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE R. Valbuena				23B. DATE SIGNED 4-21-72	
23C. PHYSICIAN'S NAME (Type) R. VALBUENA				23D. ADDRESS Bon Secours Hospital	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4/25/72		24C. NAME OF CEMETERY or CREMATORY Woodlawn Cemetery	
24D. LOCATION Baltimore, Maryland		24E. DATE REC'D BY HEALTH DEPT. APR 24 1972		24F. NAME OF REGISTRAR Robert E. Taylor, Jr.	
24G. FUNERAL DIRECTOR Witzke, 1630 Edmondson Avenue		24H. ADDRESS 21228		24I. DATE 4/25/72	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

W-635 72 03892				BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 03892	
BIRTH NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <u>Wroten, Ethel</u>				2. DATE AND HOUR OF DEATH <u>4/21/72</u> <u>2:40</u> P. M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <u>Maryland General Hosp.</u>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE <u>MD</u> B. COUNTY		C. CITY OR TOWN <u>Baltimore</u>	
D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		E. STREET AND NUMBER <u>3501 St. Paul St. Apt 932, 1202</u>					
5. SEX <u>Female</u>	6. RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5/22/188</u>	9. AGE (In years last birthday) <u>83</u>	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William Holmes</u>				14. MOTHER'S MAIDEN NAME <u>Mary Elizabeth Tucker</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>215-10-6460B</u>		17. INFORMANT ADDRESS <u>Mr. Howard E. Wroten, 3501 St. Paul St.</u>			
18. <u>412.4 + 250.7</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>Heart Failure</u> DUE TO, OR AS A CONSEQUENCE OF: <u>ASCD</u> CHF (B) DUE TO, OR AS A CONSEQUENCE OF: <u>ASCD and Post Phlebitis Syndrome</u> (C) <u>Diabetes Mellitis, Peripheral Vascular Disease</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>20 min.</u> <u>2-3 yrs.</u> <u>10 yrs.</u> <u>12 yrs.</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from _____ 19____ to _____ 19____ that (I) (we) last saw the deceased alive on _____ 19____ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>JH Ziegler M.D.</u>				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>4/21/72</u>	
23C. PHYSICIAN'S NAME (Type) <u>JH Ziegler M.D.</u>				23D. ADDRESS <u>Maryland General Hospital, Baltimore, Md.</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>4/24/72</u>		24C. NAME of CEMETERY or CREMATORY <u>Lorraine Park Cemetery</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>APR 24 1972</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor, Jr.</u>		25C. FUNERAL DIRECTOR <u>Witake, 1630 Edmondson Avenue</u>		ADDRESS <u>21228</u>	

Gray and General Post

Female White

✓

2/22/88 83

Self

2/22/88 83

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Baltimore City Health Department				REG. NO. 72 03893	
S-363 72 03893		CERTIFICATE OF DEATH			
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>ARTHUR E. STERRETT</u>		2. DATE AND HOUR OF DEATH <u>22 Apr. 72</u> <u>10:20 A.M.</u>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>Provident Hospital</u> <u>39</u>			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MD</u> B. COUNTY <u>1603</u>		
5. SEX <u>M</u>	6. RACE <u>N N</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-21-95</u>	9. AGE (In years last birthday) <u>76</u>	10. If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>	
13. FATHER'S NAME <u>Arthur Sterrett</u>		14. MOTHER'S MAIDEN NAME <u>Anna Sterrett</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>31-188-242</u>		17. INFORMANT <u>Reverend Stuart (son)</u>	
18. <u>150.9 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last <u>II</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <u>Renal Failure</u>			CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>C.V.A.</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>H.C.V.D.</u> DUE TO, OR AS A CONSEQUENCE OF: (C) <u>Diabetes Mellitus</u>		
19A. DATE OF OPERATION <u>0</u>			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED White At <input type="checkbox"/> Not White At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (X) (this hospital) attended the deceased from <u>03-27-1972</u> to <u>04-22-1972</u> that (I) (we) last saw the deceased alive on <u>04-22-1972</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>D. Rupak C. Mitra</u> MD			23B. DATE SIGNED <u>04-22-1972</u>		23C. PHYSICIAN'S NAME (Type) <u>DR RUPAK C. MITRA</u> MD
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <u>4-26-72</u>		24C. NAME OF CEMETERY or CREMATORY <u>Arbutus Memory Park, Exton, Md.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>APR 24 1972</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor</u>		25C. FUNERAL DIRECTOR <u>Robert E. Taylor</u> ADDRESS <u>1701-14 Avenue</u>	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		72 03894	
1. NAME OF DECEASED (Type or Print)		ELVORA W. WILLIAMS		2. DATE AND HOUR OF DEATH 4/17/72 1:50 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE MARYLAND B. COUNTY		907	
FULL NAME OF HOSPITAL OR INSTITUTION THE JOHNS HOPKINS HOSPITAL 33		C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER 1539 ABBOTTSON ST.					
5. SEX FEMALE	6. RACE NEGRO	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-16-16	9. AGE (In years lost birthday) 56	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Warren Co. N.C.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME LEMUEL PULLEN		14. MOTHER'S MAIDEN NAME SALLIE AUSTIN			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Mr. Jessie Williams - 1539 - Abbottson St.	
18. 436.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Respiratory Failure (B) Pneumonia DUE TO, OR AS A CONSEQUENCE OF: (C) Multiple CVA's		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 11/11/72 to 1/17/72 that (I) (we) last saw the deceased alive on 1/17/72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Harold Herderman MD		23B. DATE SIGNED 4/17/72		23C. PHYSICIAN'S NAME (Type) J HAROLD HERDERMAN MD	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE 4-22-72		24C. NAME OF CEMETERY OR CREMATORY Lee's Chapel	
24D. LOCATION Littleton, U.C.		24E. FUNERAL DIRECTOR Dyett F.H. 1206 Lawrence St.		24F. ADDRESS	
25A. DATE REC'D BY HEALTH DEPT. APR 24 1972		25B. NAME OF REGISTRAR R. E. C. 7.2.2		25C. FUNERAL DIRECTOR Dyett F.H. 1206 Lawrence St.	

THE UNITED STATES OF AMERICA

DEPT. OF JUSTICE

100-100000

RECORD

SECTION

IN THE MATTER OF

JOHN J. LEE



B-600

72 03895

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 72 03895

BIRTH NO.

1. NAME OF DECEASED (Type or Print) LOUIS BERRY		2. DATE OF DEATH Known <input type="checkbox"/> Estimated <input type="checkbox"/>		Month	Day	Year	Hour
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 46 LUTHERAN HOSPITAL		3. DATE PRONOUNCED DEAD		Month	Day	Year	Hour
				April	18	1972	7:52 P.
5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY 2037		C. CITY OR TOWN		D. INSIDE CITY LIMITS?			
		Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
6. SEX Male	7. RACE Negro	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		E. STREET AND NUMBER			
9. DATE OF BIRTH 8-16-18		10. AGE (in years last birthday) 53		3605 Edmondson Avenue			
11. BIRTHPLACE (State or foreign country) Elko, S. C.		12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME Quincey Wright			
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		14B. KIND OF BUSINESS OR INDUSTRY Cement Finishers		15. MOTHER'S MAIDEN NAME Annie Wright			
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		17. SOCIAL SECURITY NO.		18. INFORMANT ADDRESS Edward L. Berry 3605 Edmondson Avenue			
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) E9651 DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		CAUSE OF DEATH Gunshot wound of chest (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) yes			
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Home		22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 3605 Edmondson Avenue 2037			
22D. TIME (Month) (Day) (Year) (Hour) (Approx.) 4-18-72 7:30 P.		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? Shot at home			
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>		ACTUAL EXAMINER'S NAME (Type) Ronald N. Kornblum, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 4/19/72			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4-24-72		24C. NAME OF CEMETERY or CREMATORY Arbutus Menorial Park		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. APR 24 1972		25B. NAME OF REGISTRAR R. E. Jones, Jr.		25C. FUNERAL DIRECTOR ADDRESS Morton & Dyett F. H. 1701 Laurens St.			

- 1 -

... ..

... ..

... ..

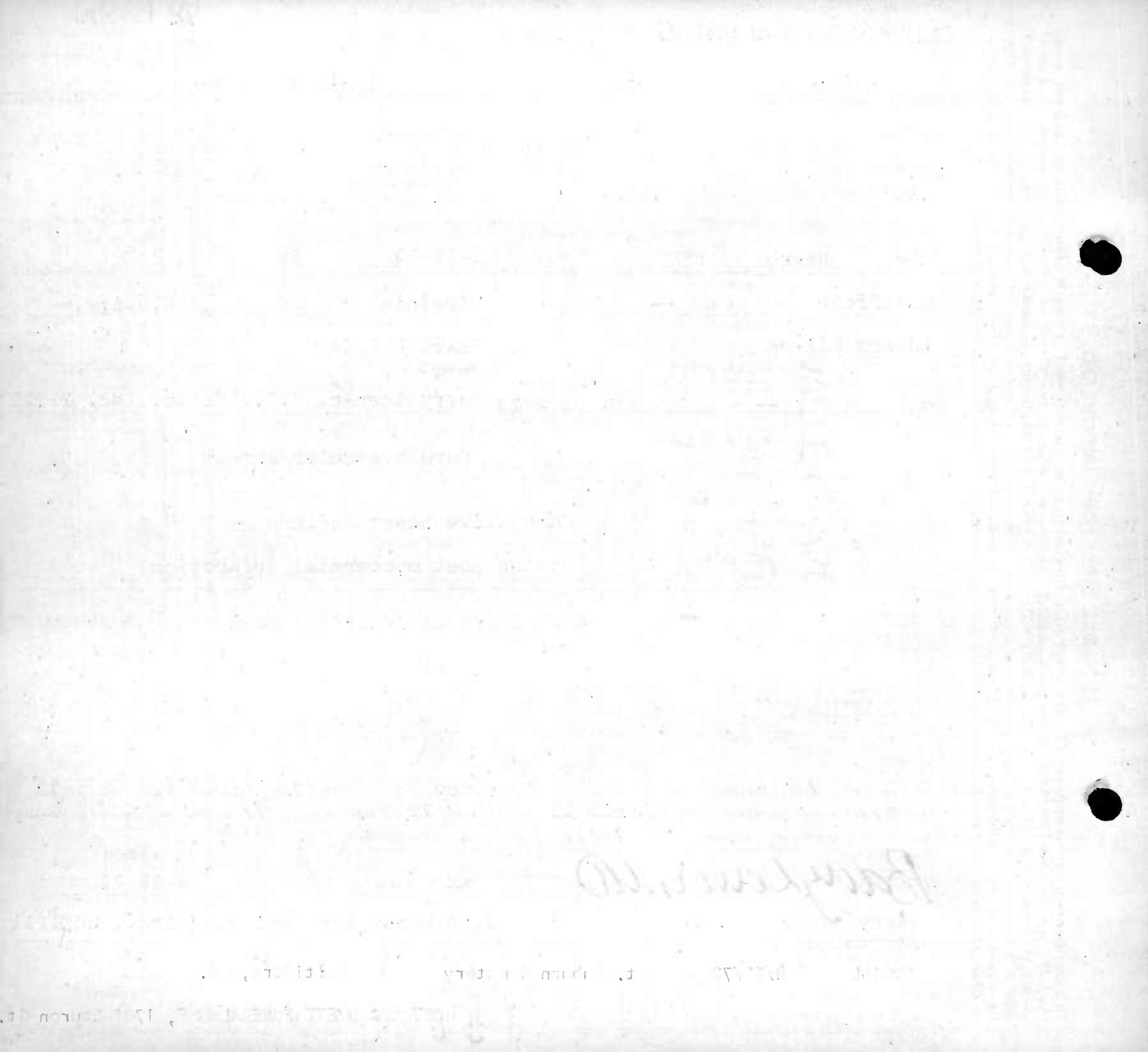
... ..

... ..

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

0-425 72 03896				BALTIMORE CITY HEALTH DEPARTMENT		72 03896	
BIRTH NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH			
WILSON, William Lewis				April 18, 1972			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 3047 Brighton Street Baltimore, Maryland 21215				A. STATE Maryland		B. COUNTY	
				C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER 3047 Brighton Street				F. STREET AND NUMBER			
				3047 Brighton Street			
5. SEX Male	6. RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9-18-12	9. AGE (In years lost birthday) 59	If Under 1 Yr. Months: Days: Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Chauffeur		10B. KIND OF BUSINESS OR INDUSTRY --		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Edward Wilson				14. MOTHER'S MAIDEN NAME Pearl Pulliam			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No --		16. SOCIAL SECURITY NO. 217 01 8773		17. INFORMANT Barry Lerner, M.D., Balto., Md. 21211			
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Cardiovascular arrest Congestive heart failure Status post myocardial infarction		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). Chronic renal insufficiency							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from February 23 19 72 to April 13 19 72, that (I) (we) last saw the deceased alive on April 13 19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.							
23A. SIGNATURE Barry Lerner, M.D.				23B. DATE SIGNED 4-18-72			
23C. PHYSICIAN'S NAME (Type) Barry Lerner, M.D.				23D. ADDRESS 3100 Wyman Park Drive, Balto., Md 21211			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 4/22/72		24C. NAME of CEMETERY or CREMATORY Mt. Auburn Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR MORTON & DYETT FUNERALHOME, 1701 Lauren St.		ADDRESS	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

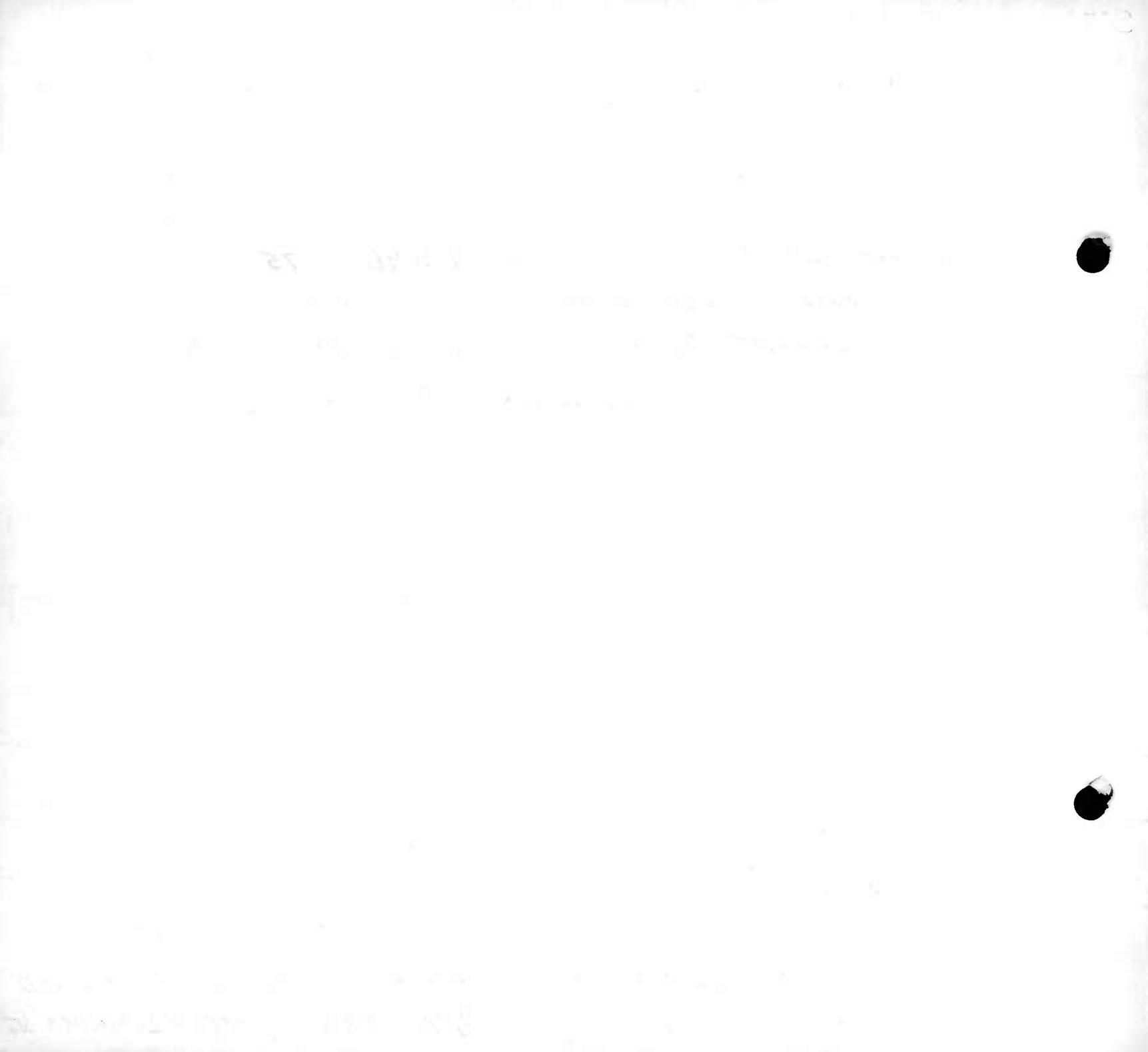
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>72 03897</u>
S-320 BIRTH NO. 1. NAME OF DECEASED (Type or Print) <u>Sadowski, Charles D.</u>		72 03897 CERTIFICATE OF DEATH		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <u>Mercy Hospital</u> <u>37</u>		2. DATE AND HOUR OF DEATH <u>4-22-72</u> <u>8:55</u> A.M.		
4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Md.</u> B. COUNTY <u>201</u>		C. CITY OR TOWN <u>Baltimore</u>		
D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		E. STREET AND NUMBER <u>1937 Gough St.</u>		
5. SEX <u>M</u>	6. RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-11-06</u>	9. AGE (In years last birthday) <u>65</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Funeral Director</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Partner</u>		
11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
13. FATHER'S NAME <u>Michael F. Sadowski</u>		14. MOTHER'S MAIDEN NAME <u>Stanislawa Zubrowski</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>212-34-4695A</u>		
17. INFORMANT (Wife) <u>Stefhanie Sadowski</u>		ADDRESS <u>1937 Gough St.</u>		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>Intra thoracic Hemorrhage</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>Carcinoma Lung</u> DUE TO, OR AS A CONSEQUENCE OF: (C) _____		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 1/2 yrs</u>		
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from _____ 19____ to _____ 19____ that (I) (we) last saw the deceased alive on _____ 19____ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <u>Louis A. Spritz M.D.</u>				23B. DATE SIGNED <u>4/22/72</u>
23C. PHYSICIAN'S NAME (Type) <u>Louis A. Spritz M.D.</u>				23D. ADDRESS <u>Mercy Hospital</u>
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>4/26/72</u>		24C. NAME OF CEMETERY OR CREMATORY <u>St. Stanislaus Cemetery</u>
24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>		25A. DATE REC'D BY HEALTH DEPT. <u>APR 24 1972</u>		
25B. NAME OF REGISTRAR <u>Reed</u>		25C. FUNERAL DIRECTOR <u>J. F. Sadowski & Sons</u>		
25D. ADDRESS <u>Baltimore, Md.</u>		25E. SIGNATURE <u>J. F. Sadowski & Sons</u>		



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				CERTIFICATE OF DEATH		REG. NO. <u>72 03898</u>	
BIRTH NO. <u>P 5472 03898</u>		1. NAME OF DECEASED (Type properly) <u>TERESA Glinzky (OR) POMLES</u>		2. DATE AND HOUR OF DEATH <u>4/21/72</u> <u>3:55 pm</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>38 University of Maryland Hospital Baltimore Md.</u>				4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>2505</u>			
5. SEX <u>FEMALE</u>		6. RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <u>9-21-96</u> 9. AGE (In years last birthday) <u>75</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LABOR</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>CROSS & BLACK WELL CO</u>		11. BIRTHPLACE (State or foreign country) <u>RUSSIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>CLEMENT SHEVCHUK</u>				14. MOTHER'S MAIDEN NAME <u>ANTONIETTE UNK.</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>214-18-7960</u>		17. INFORMANT <u>Mary G. Swift (Daughter)</u>		ADDRESS <u>above address</u>	
18. <u>427.91 + 207.9</u> CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>II</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <u>Leukemia</u>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While <input type="checkbox"/> At Work		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>4/21</u> 19 <u>72</u> to <u>4/21</u> 19 <u>72</u> that (I) (we) last saw the deceased alive on <u>4/21</u> 19 <u>72</u> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>Robert E. Greenman MD.</u>				23B. DATE SIGNED <u>4/21/72</u>			
23C. PHYSICIAN'S NAME (Type) <u>Robert E. Greenman MD</u>				23D. ADDRESS <u>829 Hillins St, Baltimore, Md.</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>APR 24 1972</u>		24C. NAME OF CEMETERY OR CREMATORY <u>HOLY TRINITY CEMETERY</u>		24D. LOCATION (City, town, or county) (State) <u>ELKRIDGE HOWARD MD</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>APR 24 1972</u>		25B. NAME OF REGISTRAR <u>Robert E. Greenman</u>		25C. FUNERAL DIRECTOR <u>DIPRE O BROS INC</u>		ADDRESS <u>1800 E LOMBARD ST</u>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

1. NAME OF DECEASED

(Type or Print)

BUTLER, John Jr.

2. DATE AND HOUR OF DEATH

4-19-72

M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

Veterans Administration Hospital
3900 Loch Raven Boulevard
Baltimore, Maryland 21218

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☐

NO ☐

E. STREET AND NUMBER

1724 E. Preston Street

5. SEX

Male

6. RACE

Negro

7. MARRIED ☒ NEVER MARRIED ☐

WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH

12-30-24

9. AGE (In years lost birthday)

47

If Under 1 Yr. Months: Days:

If Under 24 Hrs. Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Steel Worker

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Spartanburg, S. C.

12. CITIZEN OF WHAT COUNTRY?

U. S. A.

13. FATHER'S NAME

John Butler Sr.

14. MOTHER'S MAIDEN NAME

Ella Leek

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

Yes

7-2-43 to 12-6-46

16. SOCIAL SECURITY NO.

218-18-6069

17. INFORMANT VA Hospital Records

ADDRESS

Baltimore, Maryland 21218

18. I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH

Pulmonary congestion and edema, heart failure, Bronchopneumonia focal.

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

Recurrent undifferentiated carcinoma from esophageal primary, 2 large lymph node metastases.

(B) DUE TO, OR AS A CONSEQUENCE OF:

Esophageal carcinoma

(C)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).

1) Lung abscess; 2) Esophagocutaneous fistula

19A. DATE OF OPERATION

3-3-71

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

Yes

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)

21E. INJURY OCCURRED

While At Work ☐

Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from March 6, 19 72 to April 19, 19 72, that (I) (we) last saw the deceased alive on April 19, 19 72 and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (not) view the body after death.

23A. SIGNATURE

Brian D. Lowery MD

Attending Phys. ☐

Med. Director ☐

Staff Phys. ☒

23B. DATE SIGNED

23C. PHYSICIAN'S NAME (Type)

BRIAN D. LOWERY

MD

23D. ADDRESS

3900 Loch Raven Boulevard
Baltimore, Maryland 21218

24A. BURIAL CREMATION, REMOVAL (Specify)

BURIAL

24B. DATE

4/24/72

24C. NAME of CEMETERY or CREMATORY

MT. AUBURN CEMETARY

24D. LOCATION (City, town, or county) (State)

MT. WINANS BALTIMORE, MD.

25A. DATE REC'D BY HEALTH DEPT.

APR 24 1972

25B. NAME OF REGISTRAR

Valerie E. Taylor, R.S.

25C. FUNERAL DIRECTOR

WILLIAM J. SPICER 1639 N. BROADWAY BALT. MD.

ADDRESS

S-520

72 03900

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

72 03900

BIRTH NO.

1. NAME OF DECEASED (Type or Print) WALTER SIMMS		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 00 2418 Linden Avenue		3. DATE PRONOUNCED DEAD Month Day Year Hour April 21, 1972 8:00 A. M.	
5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY 1301			
6. SEX Male	7. RACE Negro	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>
9. DATE OF BIRTH 6/1/96	10. AGE (In years (lost birthday) 72 ? If Under 1 Yr. II Under 24 Hrs. Months Days Hours Min.	E. STREET AND NUMBER 2418 Linden Avenue	
11. BIRTHPLACE (State or foreign country) Montgomery County Md.		12. CITIZEN OF WHAT COUNTRY? U S A	
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		15. MOTHER'S MAIDEN NAME ???	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) Yes W W T		17. SOCIAL SECURITY NO. 218-07-8670	
18. INFORMANT Mrs. Miller, 2342 Eutaw Place,		ADDRESS ????	
19. 412.41 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. ANTECEDENT CAUSES II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		CAUSE OF DEATH Arteriosclerotic cardiovascular disease (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:	
20A. DATE OF OPERATION 0		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Ronald N. Kornblum, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED 4/24/72 ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4/27/72	
24C. NAME OF CEMETERY or CREMATORY Mt Auburn Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT. APR 24 1972		25B. NAME OF REGISTRAR Robert E. Farley, M.D.	
25C. FUNERAL DIRECTOR A Halstead 1206 W North Ave		ADDRESS	

72 03900 3095

100-11187

UNITED STATES DEPARTMENT OF JUSTICE

John M. [illegible]

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				72 03901		REG. NO. 72 03901	
BIRTH NO. <u>S-164</u>				72 03901		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <u>SADIE SPURLOCK</u>				2. DATE AND HOUR OF DEATH <u>04-22-72</u> <u>1:30 P.M.</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>Provident Hospital.</u> <u>39</u>				4. USUAL RESIDENCE (Where deceased lived, if institutions residence before admission) A. STATE <u>MD.</u> B. COUNTY <u>BALTO</u> <u>5300</u>			
5. SEX <u>F</u>		6. RACE <u>Negro</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1-27-1883</u>	
9. AGE (In years last birthday) <u>89</u>		10. UNDER 1 Yr. Months Days		11. UNDER 24 Hrs. Hours Min.		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>				10B. KIND OF BUSINESS OR INDUSTRY			
11. BIRTHPLACE (State or foreign country) <u>CHARLINA CO. VA</u>				12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>			
13. FATHER'S NAME <u>ADOLPH SPURLOCK</u>				14. MOTHER'S MAIDEN NAME <u>SADIE MORGAN</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>212-56-2309</u>		17. INFORMANT <u>WALTER SPURLOCK</u>	
18. <u>4/22/31</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>CCF.</u>		(B) <u>ASHD.</u> DUE TO, OR AS A CONSEQUENCE OF:	
(C)				(D)		(E)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				<u>Pneumonia</u>			
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH? <input type="checkbox"/> Inotify medical examiner		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?		22. I certify that (H) (this hospital) attended the deceased from <u>02-13</u> <u>1972</u> to <u>04-22</u> <u>1972</u> that (I) (we) last saw the deceased alive on <u>04-22</u> <u>1972</u> and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.		23A. SIGNATURE <u>R. Mitra</u> <u>MD</u> DEGREE	
23B. DATE SIGNED <u>04-22-72</u>		23C. PHYSICIAN'S NAME (Type) <u>RUPAK MITRA</u> <u>MD.</u> DEGREE		23D. ADDRESS <u>Provident Hospital.</u>		23E. DATE SIGNED <u>04-22-72</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>4-26-72</u>		24C. NAME of CEMETERY or CREMATORY <u>ARBURTHUS CEMETERY</u>		24D. LOCATION (City, town, or county) (State) <u>BALTO, MD.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>APR 24 1972</u>		25B. NAME OF REGISTRAR <u>Robert E. Fisher, Jr.</u>		25C. FUNERAL DIRECTOR <u>Joseph W. Hayes</u>		25D. ADDRESS <u>3112 Reist. Rd</u>	

21 55-NO 55

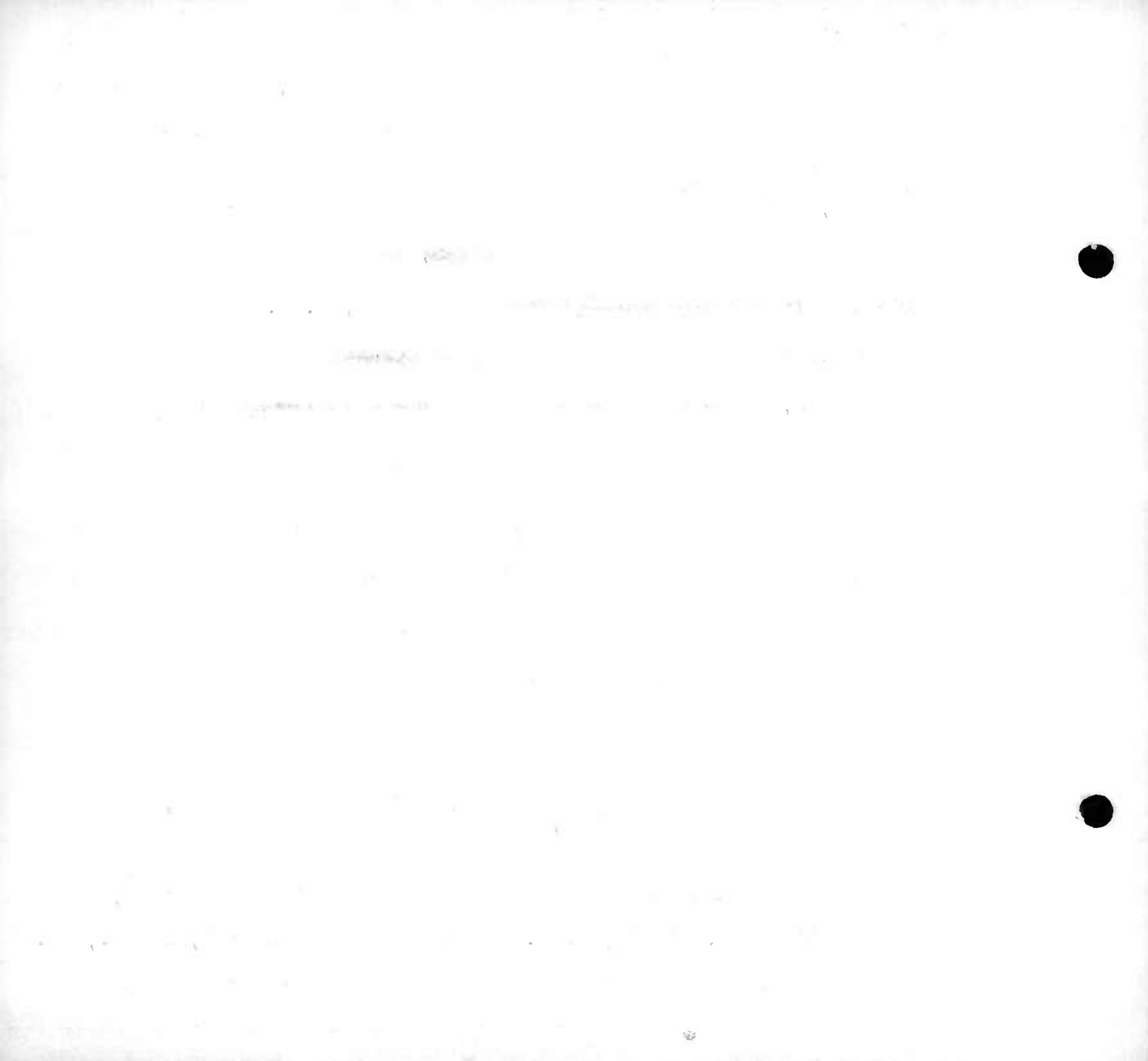
05-13 55-NO

616

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 72 03902		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 72 03902
1. NAME OF DECEASED (Type or Print) Plummer Burgess		2. DATE AND HOUR OF DEATH April 22, 1972 3:45 pm		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY Baltimore City		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Good Samaritan Hospital 5601 Loch Raven Blvd. Baltimore, Maryland 21239		C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
5. SEX Male 6. RACE Negro 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10-8-1930		9. AGE (in years last birthday) 41
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) switchman		10B. KIND OF BUSINESS OR INDUSTRY Beth. Steel		11. BIRTHPLACE (State or foreign country) Warrenton, N. C.
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Floyd Burgess		
14. MOTHER'S MAIDEN NAME Lucy Alston		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) yes Feb, 1952- 53		
16. SOCIAL SECURITY NO. 237-50-8349		17. INFORMANT Mrs. Dorothy A. Burgwss		
18. 403X1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Cardiac arrest		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 20 min		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Cerebrovascular accident		DUE TO, OR AS A CONSEQUENCE OF: 3 days		
Hypertension and uremia		4 years		
Multiple furunculosis		2 months		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				
19A. DATE OF OPERATION 18 Apr 72		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Chronic renal failure		20A. AUTOPSY? (Yes or No) Yes
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? No				
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from Apr 4, 1972 to Apr 22, 1972 that (I) (we) last saw the deceased alive on Apr 22, 1972 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE William D. Hillis, M.D.		23B. DATE SIGNED Apr 22, 1972		
23C. PHYSICIAN'S NAME (Type) William D. Hillis, M. D.		23D. ADDRESS Good Samaritan Hospital, Balto., Md.		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4-27-72		24C. NAME OF CEMETERY or CREMATORY Arbutus Meorial Park
24D. LOCATION Baltimore Co., Maryland				
25A. DATE REC'D BY HEALTH DEPT. APR 24 1972		25B. NAME OF REGISTRAR Robert E. Taylor, Jr.		25C. FUNERAL DIRECTOR NUTTER FUNERAL HOME 3035 W. NORTH AVE.



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

72 03903

BIRTH NO.

1. NAME OF DECEASED (Type or Print) William J. Holt		2. DATE OF DEATH Known <input type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour 4 17 72 4:10 P. M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 00 2228 Eutaw Place		3. DATE PRONOUNCED DEAD Month Day Year Hour 4 17 72 4:10 P. M.	
6. SEX Male		7. RACE Negro	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore	
9. DATE OF BIRTH 1/18/37		10. AGE (In years last birthday) 35	
11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Chauffeur		14B. KIND OF BUSINESS OR INDUSTRY Catering Co.	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) NO		17. SOCIAL SECURITY NO. 212-80-9022	
18. INFORMANT Isabelle Holt		ADDRESS 2033 Madison Ave.	
19. 303.21 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Chronic alcoholism		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) 4 17 72		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?		21. AUTOPSY? (Yes or No) Yes	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Deputy CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE Werner H. Spitz M.D. EXAMINER'S NAME (Type) Werner H. Spitz, M.D.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4/22/72	
24C. NAME of CEMETERY or CREMATORY Arbutus Memorial Park		24D. LOCATION (City, town, or county) (State) Baltimore Co. Md.	
25A. DATE REC'D BY HEALTH DEPT. APR 24 1972		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.	
25C. FUNERAL DIRECTOR Herbert E. Nutter		ADDRESS 3035 W. North Ave	

75-6-57

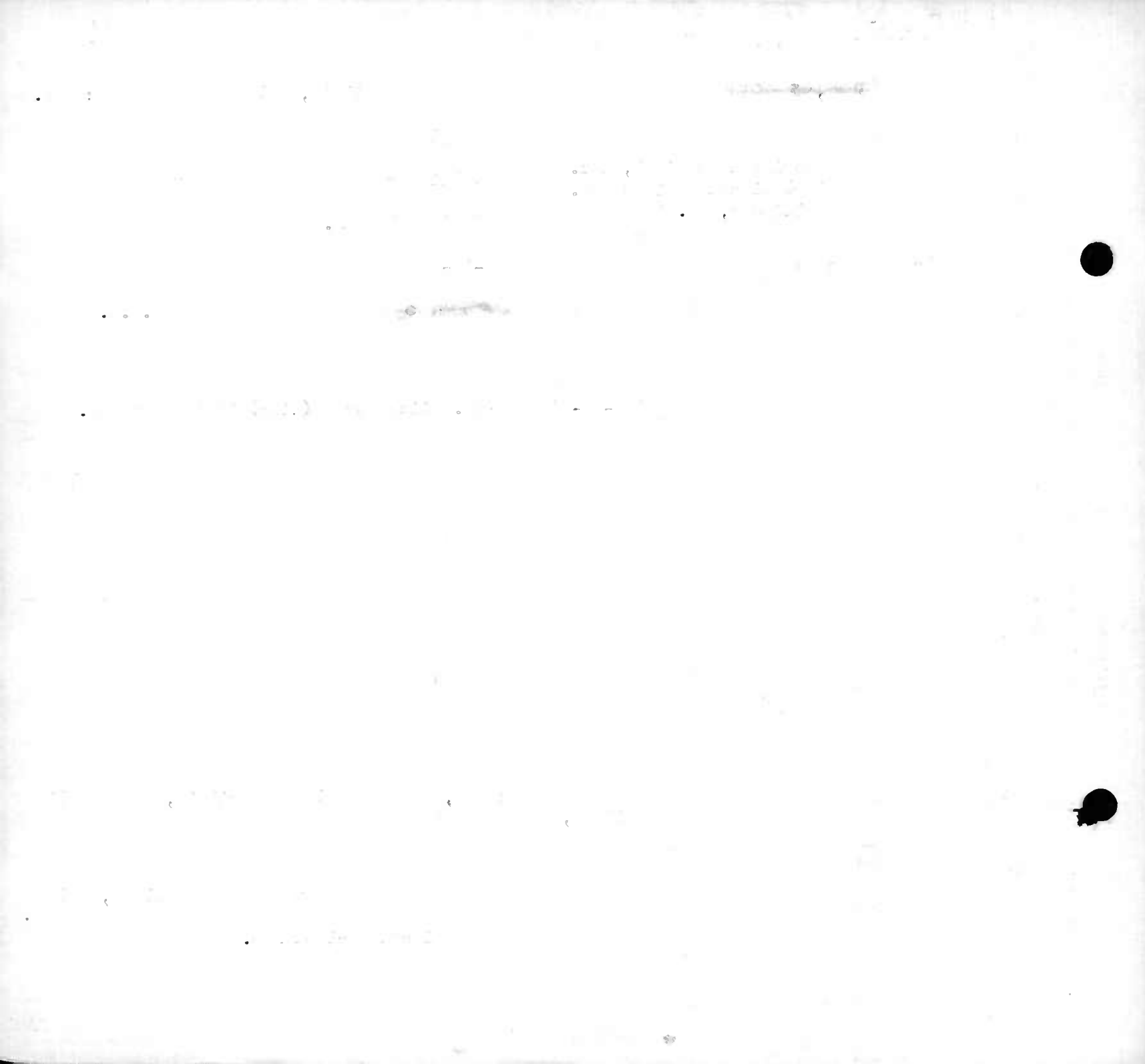
WALLEN POK

27-10-1957

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. <u>72 03904</u>
BIRTH NO. <u>M-650</u>		72 03904		
1. NAME OF DECEASED (Type or Print) <u>Charles Moran (Charlie Moran)</u>		2. DATE AND HOUR OF DEATH <u>April 20, 1972</u> <u>9:00 a.m.</u>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>2843</u>		
FULL NAME OF HOSPITAL OR INSTITUTION <u>39</u> <u>Provident Hospital, Inc.</u> <u>2600 Liberty Height Ave.</u> <u>Baltimore, Md. 21215</u>		C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
5. SEX <u>Male</u>		6. RACE <u>Negro</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer-city of Baltimore sewage dept</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Georgia</u>		11. BIRTHPLACE (State or foreign country) <u>Georgia</u>
13. FATHER'S NAME <u>Jim Moran</u>		14. MOTHER'S MAIDEN NAME <u>Mandy Evans</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>255-10-8499</u>		17. INFORMANT <u>Mrs. Alice Moran (Wife) 2914 Wynham Rd.</u>
18. <u>250.9 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>CUA</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>unknown</u>		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) <u>Diabetic Mellitus</u> DUE TO, OR AS A CONSEQUENCE OF: <u>unknown</u>		
(C) _____				
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from <u>March 21, 1972</u> to <u>April 20, 1972</u> that (I) (we) last saw the deceased alive on <u>April 20, 1972</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <u>M. A. MacA BRIGD, M.D.</u>		23B. DATE SIGNED <u>April 21, 1972</u>		23C. PHYSICIAN'S NAME (Type) <u>M. A. MacA BRIGD, M.D.</u>
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>4-25-72</u>		24C. NAME OF CEMETERY or CREMATORY <u>Mt. Auburn Cemetery</u>
25A. DATE REC'D BY HEALTH DEPT. <u>APR 24 1972</u>		25B. NAME OF REGISTRAR <u>John E. Fisher, Jr.</u>		25C. FUNERAL DIRECTOR <u>NUTTER FUNERAL HOME 3035 W. NORTH AVE.</u>



FUNERAL DIRECTOR: IMPORTANT

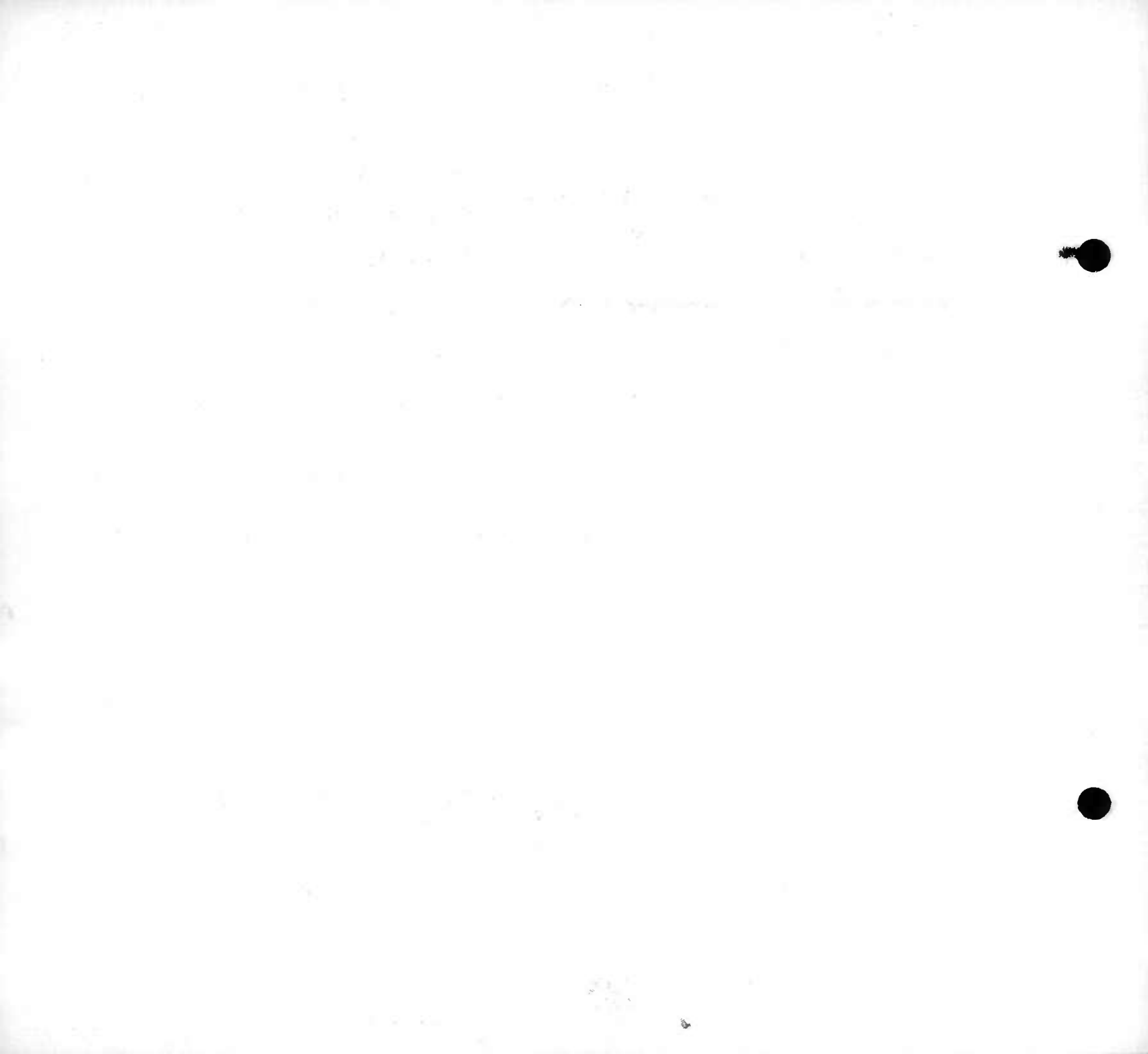
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 03905
BIRTH NO. 1. NAME OF DECEASED (Type or Print) SINGLETON, MACK B.		CERTIFICATE OF DEATH		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 39 Provident Hospital, Inc. 2600 Liberty Heights Avenue Baltimore, Maryland 21215		2. DATE AND HOUR OF DEATH 4.21.72 2:00 P.M. 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY 1504 C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 2331 North Monroe Street		
5. SEX Male	6. RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-5-1916	9. AGE (In years last birthday) 56 If Under 1 Yr. Months Days If Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) merchant seaman		10B. KIND OF BUSINESS OR INDUSTRY Georgia		
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY? U. S. A.		
13. FATHER'S NAME John Singleton		14. MOTHER'S MAIDEN NAME Mamie Strickland		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 261-05-3766		
17. INFORMANT Mrs. Emmaline Singleton		ADDRESS 2331 N. Monroe St.		
18. CAUSE OF DEATH				
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				
(A) IMMEDIATE CAUSE MYOCARDIAL INFARCTION DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C)				
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). HCD and Diabetes Mellitus				
II				
19A. DATE OF OPERATION 4-10-72 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 20A. AUTOPSY? (Yes or No) YES 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? NO				
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour)		
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from 4.20 1972 to 4.21 1972 that (I) (we) last saw the deceased alive on 4.21 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE M. J. Shafer		23B. DATE SIGNED 4/21/72		
23C. PHYSICIAN'S NAME (Type) SHAFF.		23D. ADDRESS NUTTER FUNERAL HOME 3035 W. NORTH AVE		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4-26-72		
24C. NAME OF CEMETERY or CREMATORY Arbutus Memorial Park		24D. LOCATION (City, town, or county) (State) Baltimore Co., Maryland		
25A. DATE REC'D BY HEALTH DEPT. APR 24 1972		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		
25C. FUNERAL DIRECTOR NUTTER FUNERAL HOME 3035 W. NORTH AVE				

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

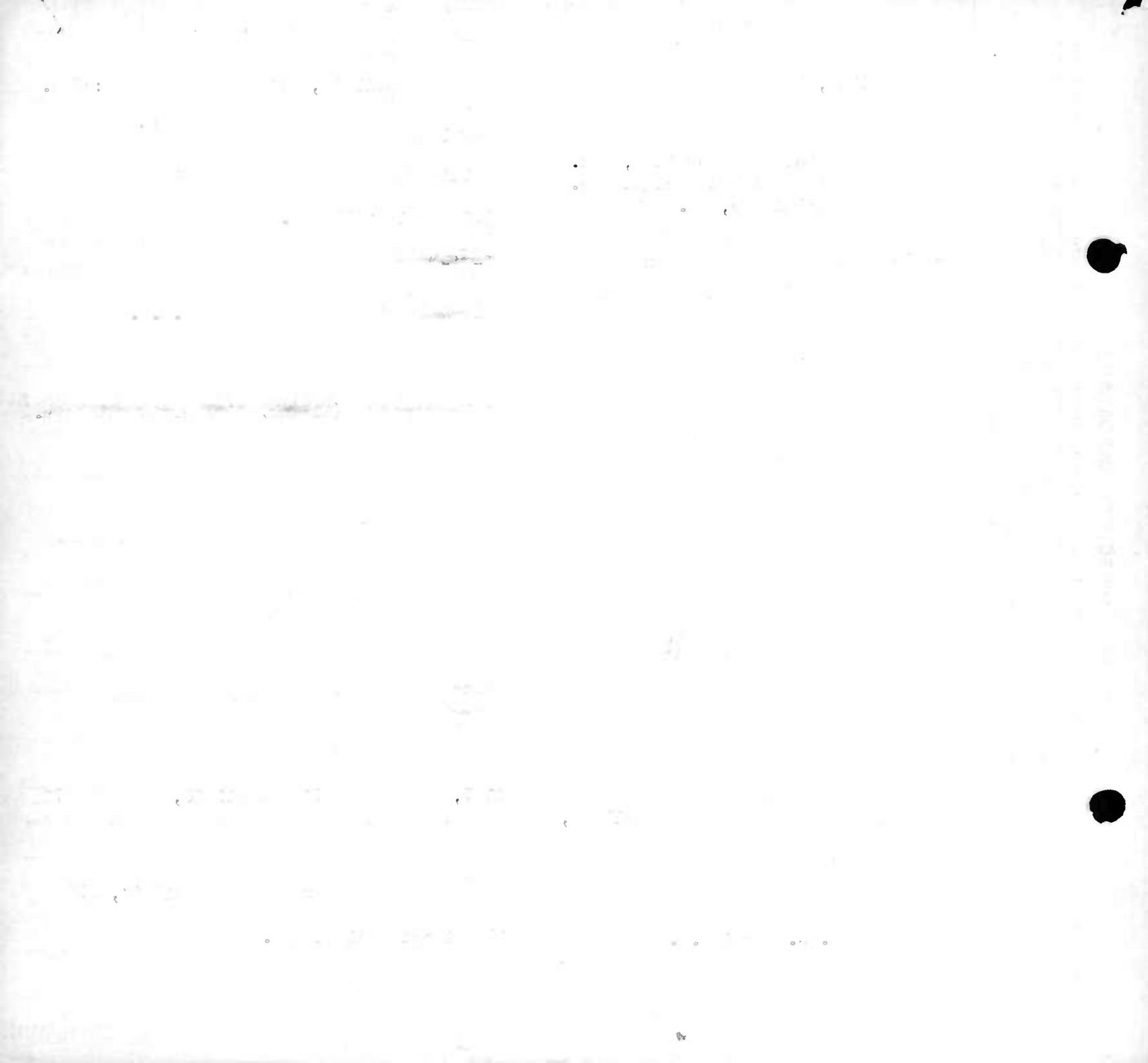
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 03906	
BIRTH NO. 1. NAME OF DECEASED (Type or Print) COSTELLO MATTHEWS		2. DATE AND HOUR OF DEATH 4/18/72 12³⁰ A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 38 University Hospital of Baltimore		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MARYLAND AA B. COUNTY 5200 5. CITY OR TOWN HANOVER 6. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 7. STREET AND NUMBER Box 72 DORSEY ROAD			
5. SEX Male	6. RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9/27/09	9. AGE (In years last birthday) 62
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) operator		10B. KIND OF BUSINESS OR INDUSTRY Produce Store		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Nicholas Matthews			
14. MOTHER'S MAIDEN NAME Rosie Oliver		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			
16. SOCIAL SECURITY NO. 717-09-8362		17. INFORMANT Mrs. Cornelia S. Matthews Box 72			
18. CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 1/93 X I ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH (A) IMMEDIATE CAUSE PULMONARY EDEMA 12 HRS DUE TO, OR AS A CONSEQUENCE OF: (B) METASTATIC CARCINOMA OF THYROID 4 YEARS DUE TO, OR AS A CONSEQUENCE OF: (C) MEDISTINAL COMPRESSION 2° to HB 3 months	
MEDICAL CERTIFICATION					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) no	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (He/this hospital) attended the deceased from 4/17/72 to 4/18/72 that (He/we) last saw the deceased alive on 4/18/72 and that in (my/our) opinion death occurred on the date and hour and from the causes stated above. (He/We) (did) (did not) view the body after death.					
23A. SIGNATURE E Mahaffey M.D.				23B. DATE SIGNED 4/18/72	
23C. PHYSICIAN'S NAME (Type) University of Maryland Hospital				23D. ADDRESS HANOVER	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4-22-72		24C. NAME of CEMETERY or CREMATORY Saints Rest Cemetery	
24D. LOCATION Hanover		24E. STATE Maryland			
25A. DATE REC'D BY HEALTH DEPT. APR 24 1972		25B. NAME OF REGISTRAR Robert E. Bailey, R.S.		25C. FUNERAL DIRECTOR ADDRESS NOTTER FUNERAL HOME 3035 W. NORTH AVE.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-400 72 03907				BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		REG. NO. 72 03907	
1. NAME OF DECEASED (Type or Print) Bailey, Bertha				2. DATE AND HOUR OF DEATH April 20, 1972 8:05 a.m.					
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY 1403					
FULL NAME OF HOSPITAL OR INSTITUTION 39		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Provident Hospital, Inc. 2600 Liberty Height Ave. Baltimore, Md. 21215		C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
5. SEX Female		6. RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 2-22-1922		9. AGE (In years last birthday) 50	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		10B. KIND OF BUSINESS OR INDUSTRY Pvt. Family		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Eugene Redmond				14. MOTHER'S MAIDEN NAME Bertha Carey					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Dorothy Butler		ADDRESS 2701 W. Garrison Ave.			
18. 5-6-7-9-1 CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Septicemia ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Peritonitis OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). HCVD with Renal Failure				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Septicemia		(B) DUE TO, OR AS A CONSEQUENCE OF: Peritonitis		(C) DUE TO, OR AS A CONSEQUENCE OF: 13 days	
19A. DATE OF OPERATION 2-2-72		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? No			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from April 7, 1972 to April 20, 1972 that (I) (we) last saw the deceased alive on April 20, 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE M. J. Shafi				23B. DATE SIGNED April 20, 1972					
23C. PHYSICIAN'S NAME (Type) M. J. Shafi M.D.		23D. ADDRESS 2600 Liberty Height Ave.							
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4-24-72		24C. NAME of CEMETERY or CREMATORY Zion Cemetery		24D. LOCATION (City, town, or county) (State) Gloucester Co., Maryland			
25A. DATE RECEIVED BY HEALTH DEPT. APR 24 1972		25B. NAME OF REGISTRAR 72 03907		25C. FUNERAL DIRECTOR NUTTER FUNERAL HOME		ADDRESS 3035 W. NORTH AVE.			



BIRTH NO.		72 03908		BALTIMORE CITY HEALTH DEPARTMENT		MEDICAL EXAMINER'S CERTIFICATE OF DEATH		72 03908		REG. NO.	
1. NAME OF DECEASED (Type or Print) Sandra Evelyn Horne						2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> April 19, 1972		Month Day Year		Hour 8:10 P. M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 46 Lutheran Hospital						3. DATE PRONOUNCED DEAD Month Day Year April 19, 1972		Month Day Year		Hour 8:10 P. M.	
5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY 1607						C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
6. SEX Female		7. RACE Negro		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		E. STREET AND NUMBER 3216 Westmont Avenue					
9. DATE OF BIRTH 10-2-1947		10. AGE (In years lost birthday) 24		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Morris E. Jackson			
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		14B. KIND OF BUSINESS OR INDUSTRY Home		15. MOTHER'S MAIDEN NAME Ruth Bevans		16. SOCIAL SECURITY NO. 218-44-7186		17. INFORMANT Mrs. Ruth Jackson		ADDRESS 3216 Westmont Avenue	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		17. SOCIAL SECURITY NO. 218-44-7186		18. INFORMANT Mrs. Ruth Jackson		ADDRESS 3216 Westmont Avenue					
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) E9651 X						CAUSE OF DEATH (A) IMMEDIATE CAUSE Gunshot wounds of head DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
20. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II						(B) DUE TO, OR AS A CONSEQUENCE OF:					
21. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).						(C) DUE TO, OR AS A CONSEQUENCE OF:					
20A. DATE OF OPERATION 0		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED				21. AUTOPSY? (Yes or No) No					
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) House		22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 3216 W. Mount Avenue		22D. TIME OF INJURY (APPROX.) 4-18-72 ?		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? Shot during altercation	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL EXAMINER'S NAME (Type) Charles S. Springate, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>		ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED April 20, 1972			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 2-24-72		24C. NAME OF CEMETERY or CREMATORY Arbutus Memorial Park		24D. LOCATION (City, town, or county) (State) Baltimore Co., Maryland					
25A. DATE REC'D BY HEALTH DEPT. APR 24 1972		25B. NAME OF REGISTRAR Robert E. Springate		25C. FUNERAL DIRECTOR NUTTER FUNERAL HOME		ADDRESS 3035 W. NORTH AV					

FIELD ST.

30-10-1938

RECEIVED BY THE OFFICE OF THE SECRETARY OF THE ARMY

OFFICE OF THE SECRETARY OF THE ARMY

WASHINGTON, D. C.

1. The following information is being furnished to you for your information:

2. The following information is being furnished to you for your information:

3. The following information is being furnished to you for your information:

4. The following information is being furnished to you for your information:

5. The following information is being furnished to you for your information:

6. The following information is being furnished to you for your information:

7. The following information is being furnished to you for your information:

8. The following information is being furnished to you for your information:

9. The following information is being furnished to you for your information:

10. The following information is being furnished to you for your information:

11. The following information is being furnished to you for your information:

12. The following information is being furnished to you for your information:

13. The following information is being furnished to you for your information:

14. The following information is being furnished to you for your information:

15. The following information is being furnished to you for your information:

16. The following information is being furnished to you for your information:

17. The following information is being furnished to you for your information:

18. The following information is being furnished to you for your information:

19. The following information is being furnished to you for your information:

20. The following information is being furnished to you for your information:

21. The following information is being furnished to you for your information:

22. The following information is being furnished to you for your information:

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH										REG. NO. <u>72 03909</u>
4-163 BIRTH NO.		72 03909 1. NAME OF DECEASED (Type or Print) <u>Thomas Leland Hubbard</u>				2. DATE AND HOUR OF DEATH <u>4/15/72</u> <u>8-00 A.M.</u>				
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <u>Lutheran Hosp</u>					4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Md</u> B. COUNTY <u>2802</u>					
FULL NAME OF HOSPITAL OR INSTITUTION <u>46</u> <u>Lutheran Hosp</u> (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)					C. CITY OR TOWN <u>Balt.</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
5. SEX <u>Male</u>		6. RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>7-4-88</u>		9. AGE (In years last birthday) <u>83</u>		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired - Stockman</u>					10B. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country) <u>Dorchester Co., Md.</u>		
13. FATHER'S NAME <u>Thomas R. Hubbard</u>					14. MOTHER'S MAIDEN NAME <u>Katie Tucker</u>					
15. Was Deceased Ever In U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>212-18-2877</u>		17. INFORMANT ADDRESS <u>Duryea Hubbard - Same</u>						
18. <u>441-1</u> I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>HAEMORRHAGE</u> DUE TO, OR AS A CONSEQUENCE OF: <u>RUPTURE THORACIC ANEURYSM</u> DUE TO, OR AS A CONSEQUENCE OF: DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>II</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			20A. AUTOPSY? (Yes or No) <u>NO</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?					
22. I certify that the (this hospital) attended the deceased from <u>4/14</u> 19 <u>72</u> to <u>4/15</u> 19 <u>72</u> that we (we) last saw the deceased alive on <u>4/15</u> 19 <u>72</u> and that in my (our) opinion death occurred on the date and hour and from the causes stated above, we (We) (did) (did not) view the body after death.										
23A. SIGNATURE <u>Sein Lwin</u>					23B. DATE SIGNED <u>4/15/72</u>			23C. PHYSICIAN'S NAME (Type) <u>Sein Lwin</u>		
23D. ADDRESS <u>LUTHERAN HOSPITAL</u>					23E. ADDRESS					
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>4-18-72</u>		24C. NAME OF CEMETERY or CREMATORY <u>Spedden-Sewards Cemetery</u>			24D. LOCATION (City, town, or county) (State) <u>Hudson, Maryland</u>			
25A. DATE REC'D BY HEALTH DEPT. <u>APR 24 1972</u>		25B. NAME OF REGISTRAR <u>Robert E. J. [unclear]</u>			25C. FUNERAL DIRECTOR ADDRESS <u>Armatost Funeral Chapel-4600 Liberty Hgts</u>					

THE JOURNAL OF THE

THE JOURNAL OF THE

THE JOURNAL OF THE

THE JOURNAL OF THE

THE JOURNAL OF THE

THE JOURNAL OF THE

THE JOURNAL OF THE

THE JOURNAL OF THE

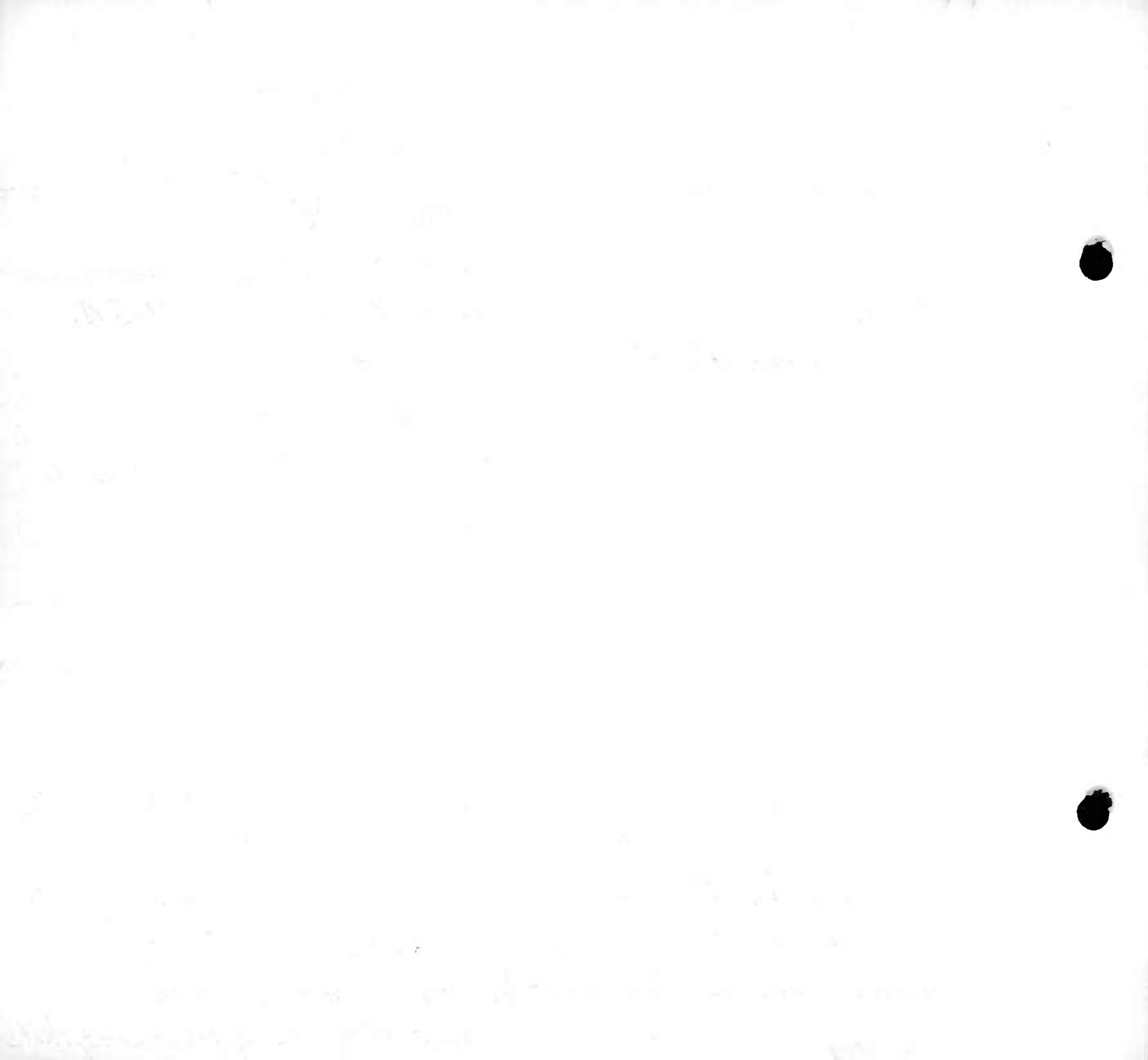
THE JOURNAL OF THE

THE JOURNAL OF THE

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

C-435		72 03910		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 03910	
BIRTH NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <i>ERMINNA Lillian Colton</i>				2. DATE AND HOUR OF DEATH <i>4-16-72</i> <i>11:00 P.M.</i>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>MARYLAND</i> B. COUNTY <i>2802</i>			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <i>5521 Norwood Ave</i>				C. CITY OR TOWN <i>5521 Norwood Ave</i>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <i>Baltimore</i>			
5. SEX <i>Female</i>	6. RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>9-15-1870</i>	9. AGE (In years last birthday) <i>101</i>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>At Home</i>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>BALTO., Co. Md</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Wilbur M. Hillis</i>				14. MOTHER'S MAIDEN NAME <i>Hook</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <i>EDNA E. Colton - Same</i>		ADDRESS	
18. <i>433.9 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <i>Cerebro-vascular thrombosis</i> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <i>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) Cerebral arteriosclerosis DUE TO, OR AS A CONSEQUENCE OF: (C)</i>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>3 days</i> <i>10 years</i>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <i>April 14, 1969</i> to <i>April 16, 1972</i> that (I) (we) last saw the deceased alive on <i>April 1, 1972</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
23A. SIGNATURE <i>Marvin Goldstein, M.D.</i>				Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <i>April 17, 1972</i>	
23C. PHYSICIAN'S NAME (Type) <i>MARVIN GOLDSTEIN, M.D.</i>		23D. ADDRESS <i>6001 Park Heights Ave. Balto. Md.</i>					
24A. BURIAL CREMATION, REMOVAL (Specify) <i>BURIAL</i>		24B. DATE <i>4-20-72</i>		24C. NAME of CEMETERY or CREMATORY <i>Greenmount Cemetery</i>		24D. LOCATION (City, town, or county) (State) <i>Baltimore, Md</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>APR 24 1972</i>		25B. NAME OF REGISTRAR <i>Robert E. Faber</i>		25C. FUNERAL DIRECTOR <i>Armstrong Funeral Chapel</i>		ADDRESS <i>4600 Liberty Hgts</i>	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <u>S-530</u>		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. <u>72 03911</u>	
1. NAME OF DECEASED (Type or Print) <u>Agatha Smith</u>			2. DATE AND HOUR OF DEATH <u>4-17-72</u> at <u>10:20 A.</u> M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <u>46 Lutheran Hospital</u> (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>1506</u> C. CITY OR TOWN <u>Balto.</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>2739 Baker St.</u>		
5. SEX <u>Female</u>	6. RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6-13-92</u>	9. AGE (In years last birthday) <u>79</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>Charles Liebaugh</u>			14. MOTHER'S MAIDEN NAME <u>Unknown</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS <u>MARIE Audrey Jefferson - 7714 Lee Drive</u>		
18. <u>427.0 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH <u>Congestive Heart failure</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>48 hrs.</u> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No) <u>NO</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At <input type="checkbox"/> Work	21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from <u>4-15-1972</u> to <u>4-17-1972</u> that (I) (we) last saw the deceased alive on <u>4-17-1972</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>J. Sampat</u> M.D. DEGREE			23B. DATE SIGNED		23C. PHYSICIAN'S NAME (Type) <u>J. SAMPAT</u>
23D. ADDRESS <u>Lutheran Hospital of Md.</u>					
24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE <u>4-20-72</u>	24C. NAME OF CEMETERY OR CREMATORY <u>Louisa Park Cemetery - Balto, Md.</u>	24D. LOCATION (City, town, or county) (State)		
25A. DATE REC'D BY HEALTH DEPT. <u>APR 24 1972</u>	25B. NAME OF REGISTRAR <u>Robt E. J. [illegible]</u>	25C. FUNERAL DIRECTOR <u>Funeral Chapel - 4600 Liberty Hgts</u>	ADDRESS		

FUNERAL DIRECTOR: IMPORTANT

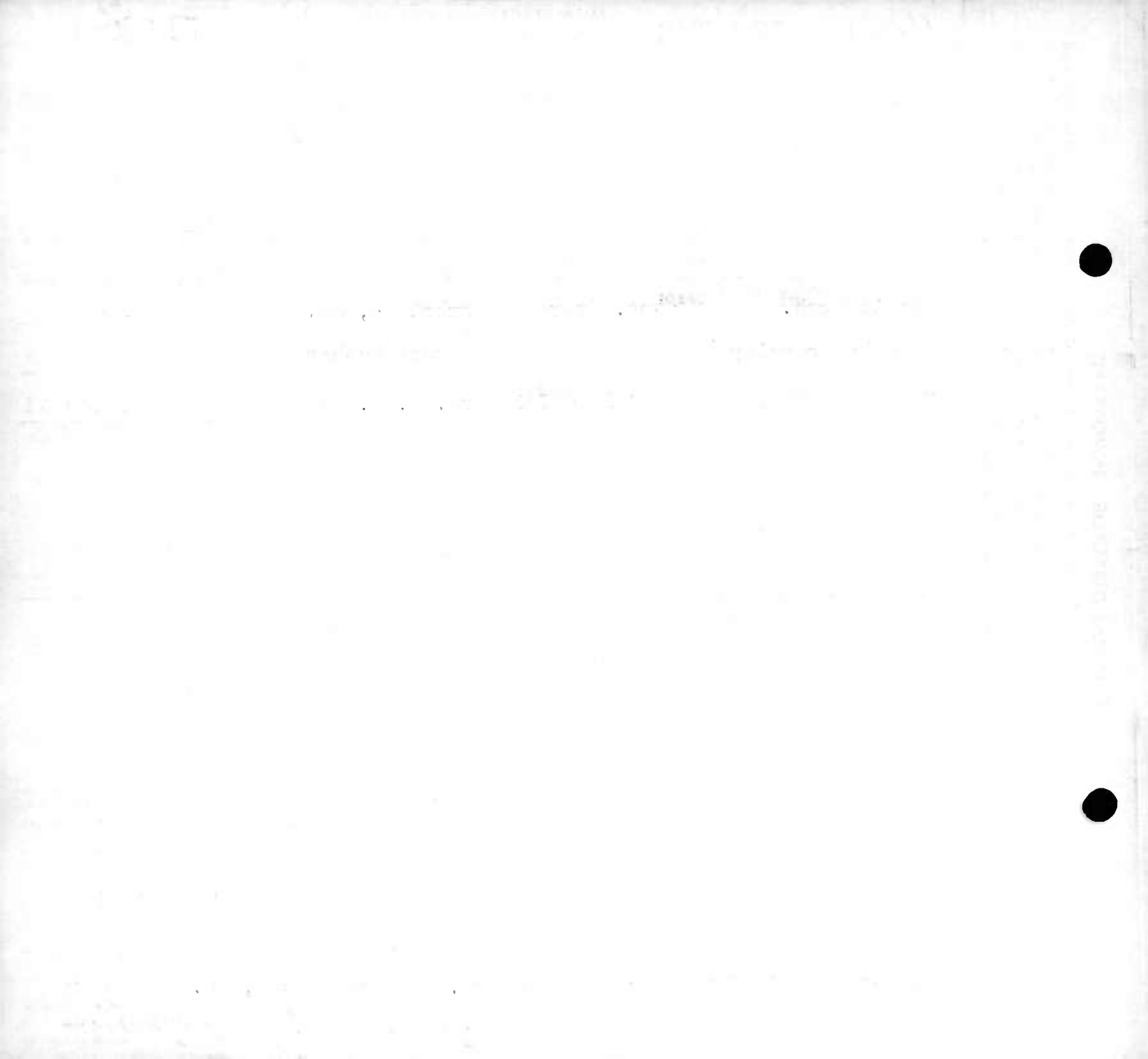
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT 72 03912 CERTIFICATE OF DEATH									
BIRTH NO. B-625		72 03912							
1. NAME OF DECEASED (Type or Print) ELSIE B. BORGMANN					2. DATE AND HOUR OF DEATH APRIL 17, 1972 5:40 P. M.				
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) SINAI HOSPITAL OF BALTIMORE INC.					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY BALTO C. CITY OR TOWN BALTO. D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER 2120 LORRAINE AVE				
5. SEX F	6. RACE C N	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8/18/02	9. AGE (in years last birthday) 69	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Waitress		11. BIRTHPLACE (State or foreign country) Baltimore, Md	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Waitress					10B. KIND OF BUSINESS OR INDUSTRY		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Joseph Armstrong					14. MOTHER'S MAIDEN NAME Rhoda Compton				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)					16. SOCIAL SECURITY NO. +		17. INFORMANT WILMER R. BORGMANN - Same ADDRESS		
18. 18301 CAUSE OF DEATH									
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) GENERALIZED CARCINOMATOSIS					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. CARCINOMA OF THE OVARY					16 MONTHS				
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).									
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (Approx.)		21E. INJURY OCCURRED			21F. HOW DID INJURY OCCUR?				
22. I certify that (I) (this hospital) attended the deceased from APRIL 15 19 72 to APRIL 17 19 72 that (I) (we) last saw the deceased alive on APRIL 17 19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.		23A. SIGNATURE [Signature] M.D. DEGREE			Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED APRIL 17, 1972		
23C. PHYSICIAN'S NAME (Type) DANIEL MIRELMAN M.D. DEGREE		23D. ADDRESS SINAI HOSP OF BALTIMORE							
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 4-22-72		24C. NAME OF CEMETERY OR CREMATORY LORRAINE Cemetery		24D. LOCATION (City, town, or county) Baltimore, Md		(State)	
25A. DATE REC'D BY HEALTH DEPT. APR 24 1972		25B. NAME OF REGISTRAR Robert E. J. [Signature] M.D.		25C. FUNERAL DIRECTOR Arroyo Funeral Chapel - 4600 Lib. Hgts		ADDRESS			

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				CERTIFICATE OF DEATH		REG. NO. <u>72 03913</u>	
BIRTH NO. <u>M-240</u>		72 03913					
1. NAME OF DECEASED (Type or Print) <u>Thomas E. McCauley</u>				2. DATE AND HOUR OF DEATH <u>4/12/72</u> <u>1:25 P.M.</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Md</u> B. COUNTY <u>Balt</u>			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>MARYLAND GENERAL HOSPT</u> <u>Baltimore, Md.</u>				C. CITY OR TOWN <u>Baltimore</u>		D. (INSIDE CITY LIMITS?) YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <u>M</u> 6. RACE <u>W</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH <u>10/25/1891</u>		9. AGE (In years last birthday) <u>80</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Radio Tech.</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Dept. Store</u>		11. BIRTHPLACE (State or foreign country) <u>Cambridge, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>	
13. FATHER'S NAME <u>John McCauley</u>				14. MOTHER'S MAIDEN NAME <u>Mary Hubbard</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service <u>Yes</u> <u>WW I</u>		16. SOCIAL SECURITY NO. <u>213 09 7535</u>		17. INFORMANT <u>Mrs. T. E. McCauley</u> ADDRESS <u>6815 Blenheim Rd</u>			
18. <u>410.9 I</u> CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)				(A) IMMEDIATE CAUSE <u>Acute MI</u> DUE TO, OR AS A CONSEQUENCE OF:			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) <u>ASCVD</u> DUE TO, OR AS A CONSEQUENCE OF:			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <u>Acute duodenal ulcer</u>				(C) _____			
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>4/16</u> 19 <u>72</u> to <u>4/17</u> 19 <u>72</u> that (I) (we) last saw the deceased alive on <u>4/17</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>Michael J. Faulstich</u> MD				23B. DATE SIGNED <u>4/17/72</u>		23C. PHYSICIAN'S NAME (Type) <u>Michael J. Faulstich</u>	
23D. ADDRESS <u>6500 York Rd</u>				23E. FUNDING DIRECTOR <u>Michael J. Faulstich</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>4/20/72</u>		24C. NAME OF CEMETERY or CREMATORY <u>Lorraine Park Cem.</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		25D. ADDRESS	
<div style="display: flex; justify-content: space-between;"> APR 24 1972 Robert E. Jones </div>							



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. <u>72 03914</u>	
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
Frank X. Wells		April 16, 1972			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			A. STATE B. COUNTY		
00 6101 Loch Raven Blvd.			Md. Baltimore 2758		
5. SEX			6. RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
Male			White		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH		9. AGE (In years last birthday)		10. UNDER 1 Yr. Months Days	
Oct 28, 1890		81			
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?			
Michigan		USA			
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
Albert Wells			Unknown		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
No		386 01 8684		Mr. Donald J. Wells 6310 York Rd.	
18. CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH					
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)					
ANTECEDENT CAUSES					
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
<p>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Myocardial Infarction</u></p> <p>(B) <u>Arteriosclerosis - C - V Dis</u></p> <p>(C) _____</p>					
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 hrs</u>					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Approx.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from <u>Jan 1</u> 19 <u>53</u> to <u>April 6</u> 19 <u>72</u>					
that (I) (we) last saw the deceased alive on <u>April 15</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
<u>Charles E. Carr Jr MD</u>				<u>4/18/72</u>	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
<u>CHARLES E. CARR JR MD</u>				<u>3400 N. CHARLES ST BALTO MD</u>	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY	
Burial		4/19/72		Dulaney Valley Mem. Gds	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
APR 24 1972		<u>Robert E. Taylor</u>		<u>Mitchell Wiedefeld Home 6500 York Rd.</u>	

1000 1000 1000

1000 1000 1000

1000 1000 1000

1000 1000 1000

1000 1000 1000

1000 1000 1000

1000 1000 1000

1000 1000 1000

1000 1000 1000

1000 1000 1000

1000 1000 1000

1000 1000 1000

1000 1000 1000

1000 1000 1000

1000 1000 1000

1000 1000 1000

1000 1000 1000

1000 1000 1000

1000 1000 1000

1000 1000 1000

1000 1000 1000

1000 1000 1000

1000 1000 1000

1000 1000 1000

1000 1000 1000

1000 1000 1000

1000 1000 1000

1000 1000 1000

1000 1000 1000

1000 1000 1000

1000 1000 1000

1000 1000 1000

1000 1000 1000

1000 1000 1000

1000 1000 1000

1000 1000 1000

1000 1000 1000

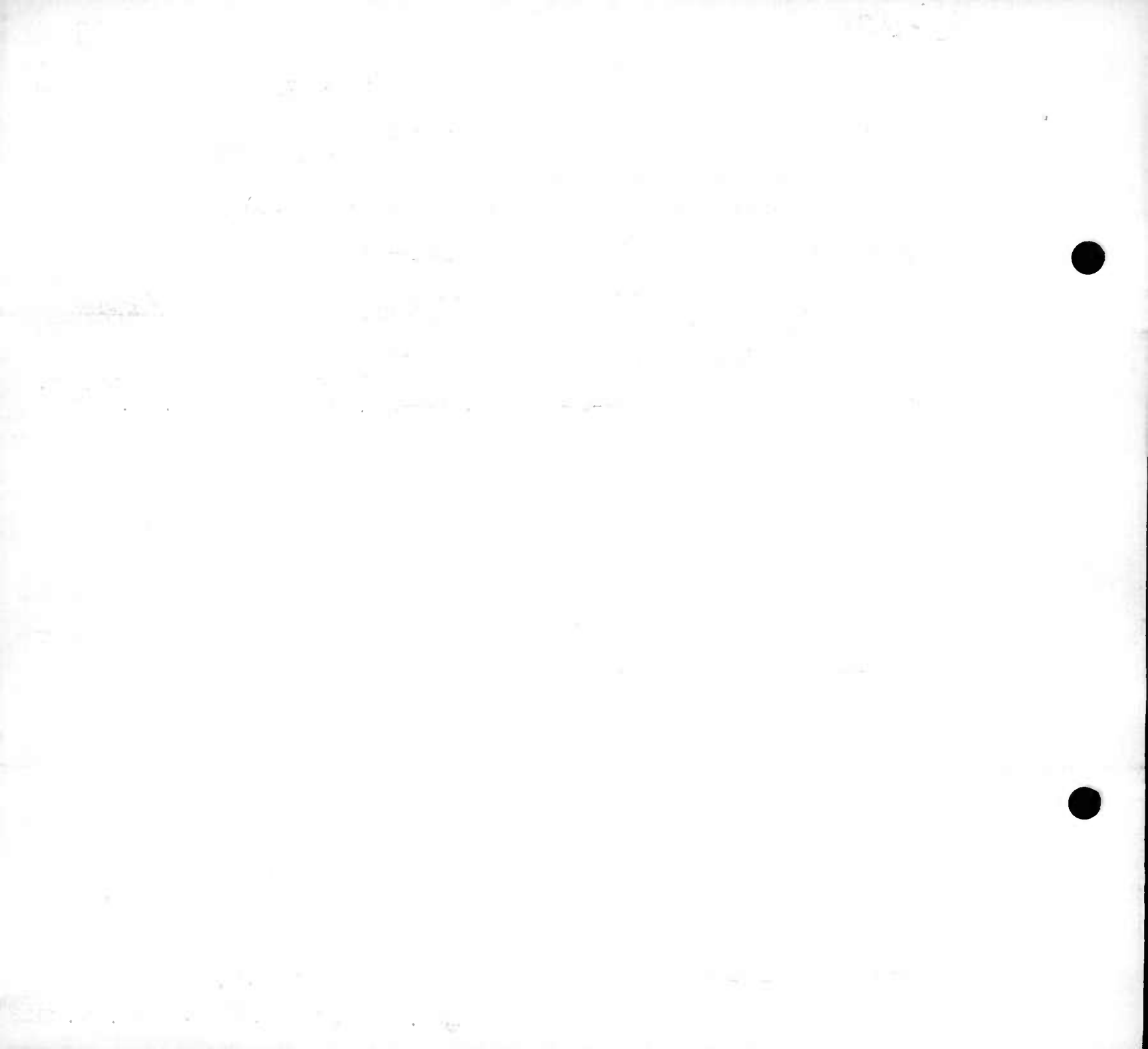
1000 1000 1000

1000 1000 1000

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

<div style="display: flex; justify-content: space-between;"> C-220 72 03915 BALTIMORE CITY HEALTH DEPARTMENT </div> <h2 style="text-align: center;">CERTIFICATE OF DEATH</h2>		REG. NO. <u>72 03915</u>	
1. NAME OF DECEASED (Type or Print) <u>Sophie Cichowicz</u> <u>Cichowicz Sophie</u>		2. DATE AND HOUR OF DEATH <u>4-18-72</u> <u>3⁰⁵ P.M.</u>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>35 B CHURCH Home and Hospital</u>		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>104</u> C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>2312 Cambridge Street</u>	
5. SEX <u>Female</u>	6. RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5-26-07</u>
9. AGE (In years last birthday) <u>64</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William Stasiak</u> <u>William Stasiak</u>		14. MOTHER'S MAIDEN NAME <u>Stella</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>212-09-1677</u>	
17. INFORMANT <u>Husband:</u> <u>Mr. Joseph P. Cichowicz</u>		ADDRESS <u>2312 Cambridge St. Balto. Md. 21224</u>	
18. <u>4/10/72</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>Myocardial infarction</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>12 hours</u>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>ASHD</u>		(B) <u>Years</u> DUE TO, OR AS A CONSEQUENCE OF:	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>None</u>			
19A. DATE OF OPERATION <u>0</u>	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>—</u>	20A. AUTOPSY? (Yes or No) <u>No</u>	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) <u>—</u>	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR? <u>—</u>	
22. I certify that (I) (this hospital) attended the deceased from <u>4-18-1972</u> to <u>4-18-1972</u> that (I) (we) last saw the deceased alive on <u>23⁰⁰ PM 4-18-72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <u>DR SAJADI</u> M.D.		23B. DATE SIGNED <u>4/18/72</u>	
23C. PHYSICIAN'S NAME (Type) <u>R. SAJADI</u> M.D.		23D. ADDRESS <u>CHURCH HOME & HOSPITAL</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>	24B. DATE <u>4-22-72</u>	24C. NAME OF CEMETERY OR CREMATORY <u>Holy Roasry Cemetery</u>	24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>
25A. DATE REC'D BY HEALTH DEPT. <u>APR 24 1972</u>		25B. NAME OF REGISTRAR <u>John J. Duda</u>	
25C. FUNERAL DIRECTOR <u>John J. Duda</u>		ADDRESS <u>2829 Hudson St. Balto. Md. 21224</u>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

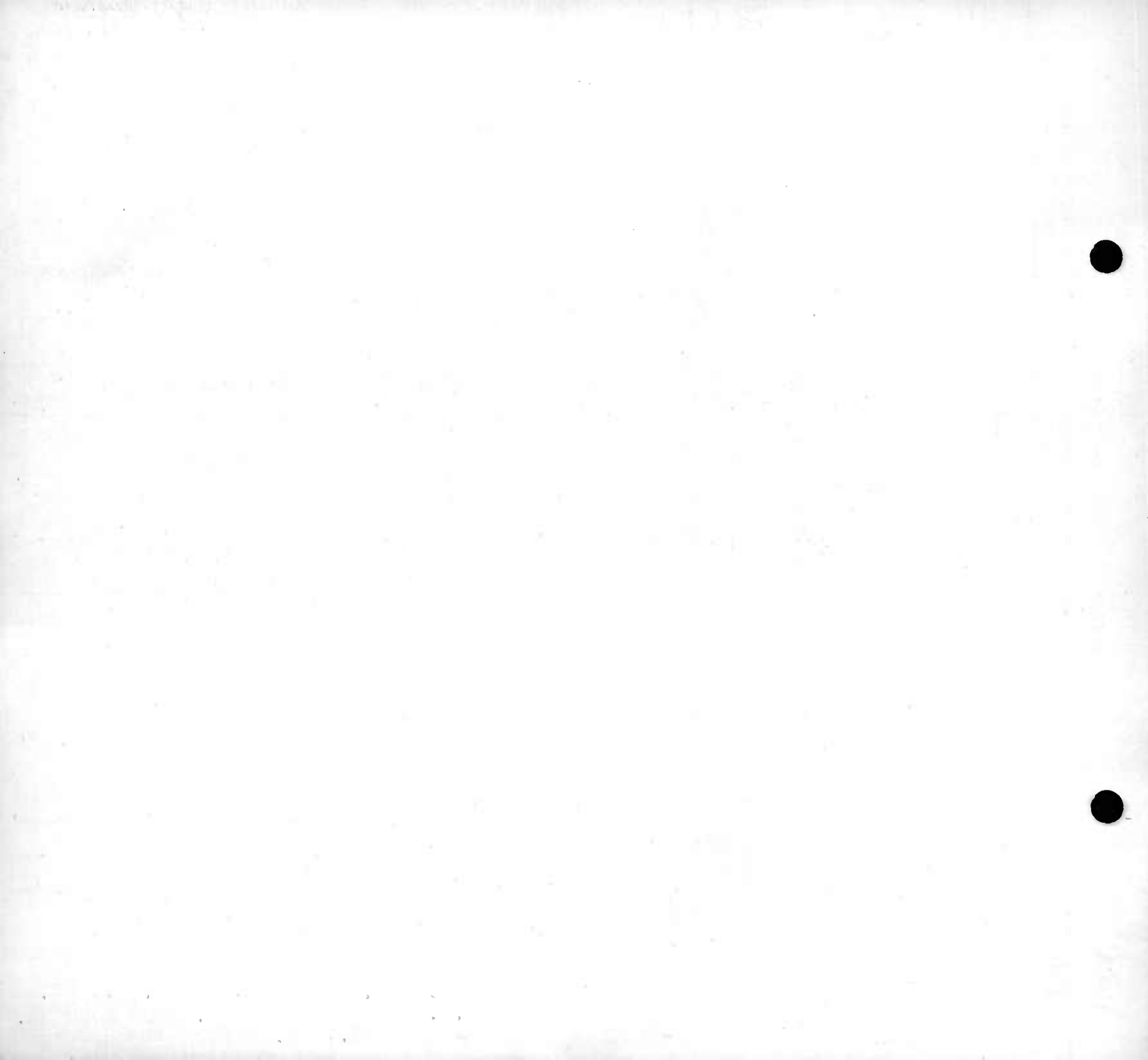
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>72 03916</u>	
S-530 BIRTH NO.		72 03916		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <u>Smith, Dora Ryan</u>			2. DATE AND HOUR OF DEATH <u>4-21-72</u> <u>8:30 A.M.</u> M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>37 Mercy Hospital</u>			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>1203</u> C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>447 E. Lorraine Ave. 21218</u>		
5. SEX <u>FEMALE</u>	6. RACE <u>CAUCASIAN</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>7/5/1892</u>	9. AGE (in years last birthday) <u>79</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Cashier</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Theatre</u>		11. BIRTHPLACE (State or foreign country) <u>England</u>	
13. FATHER'S NAME <u>?</u>		14. MOTHER'S MAIDEN NAME <u>?</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>416-05-5633A</u>		17. INFORMANT <u>Thomas Ryan (Same)</u>	
18. <u>155.8</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). 19A. DATE OF OPERATION <u>4/16</u> 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Ca of Carcinoma of colon</u> 20A. AUTOPSY? (Yes or No) <u>YES</u> 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>YES</u> 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>Generalized arteriosclerosis</u> 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> 21F. HOW DID INJURY OCCUR? 22. I certify that (I) (this hospital) attended the deceased from <u>4/16</u> 19 <u>72</u> to <u>4/21</u> 19 <u>72</u> that (I) (we) last saw the deceased alive on <u>4/21</u> 19 <u>72</u> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. 23A. SIGNATURE <u>Tolhu OHE</u> 23B. DATE SIGNED <u>4/22/72</u> 23C. PHYSICIAN'S NAME (Type) <u>Tolhu OHE</u> 23D. ADDRESS <u>Mercy Hospital, Baltimore, MD</u> 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> 24B. DATE <u>4/24/72</u> 24C. NAME of CEMETERY or CREMATORY <u>Gardens of Faith</u> 24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u> 25A. DATE REC'D BY HEALTH DEPT. <u>APR 24 1972</u> 25B. NAME OF REGISTRAR <u>Re...</u> 25C. FUNERAL DIRECTOR <u>H.W. Jenkins & Sons Co.</u> ADDRESS <u>4905 York Rd. Balto, Md. 21212</u>					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
7-525 72 03917					72 03917				
BIRTH NO.					REG. NO.				
1. NAME OF DECEASED (Type or Print) HERBERT FANKHANE L					2. DATE AND HOUR OF DEATH 4/21/72 17:15 P.M.				
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD. B. COUNTY BALTIMORE				
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) NORTH CHARLES GENERAL HOSP. 49					C. CITY OR TOWN TOWSON		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
					E. STREET AND NUMBER 8210 LOCH RAVEN BLVD.				
5. SEX M	6. RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/5/95	9. AGE (In years last birthday) 76	If Under 1 Yr. Months: Days: Hours: Min.		If Under 24 Hrs. Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) TEACHER			10B. KIND OF BUSINESS OR INDUSTRY EDUCATION		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME ALBERT L. FANKHANE L					14. MOTHER'S MAIDEN NAME MARGARET BIEN				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes - Army WWII			16. SOCIAL SECURITY NO. 216148960		17. INFORMANT MRS. A. LORETTA FANKHANE L			ADDRESS (SAME AS DECEASED) NORTH CHARLES GENERAL HOSPITAL CHART	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) CARCINOMA, LUNG					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.									
II									
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).									
19A. DATE OF OPERATION 4/21/72		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (H) (this hospital) attended the deceased from 4/21 19 72 to 4/21 19 72 , that (H) (we) last saw the deceased alive on 4/21 19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE RUFINO G. MONTEVEGRO M.D.					23B. DATE SIGNED 4/21/72				
23C. PHYSICIAN'S NAME (Type) RUFINO G. MONTEVEGRO M.D.					23D. ADDRESS 2724 North CHARLES, Balto. Md.				
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4/25/72		24C. NAME OF CEMETERY or CREMATORY Dulaney Valley Mem. Grds., Timonium, Balto. Co., Md.		24D. LOCATION (City, town, or county) (State) Balto., Md.			
25A. DATE REC'D BY HEALTH DEPT. APR 24 1972		25B. NAME OF REGISTRAR R. E. Jenkins		25C. FUNERAL DIRECTOR H. W. Jenkins & Sons Co.		ADDRESS 4905 York Rd. Balto., Md. 21212			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

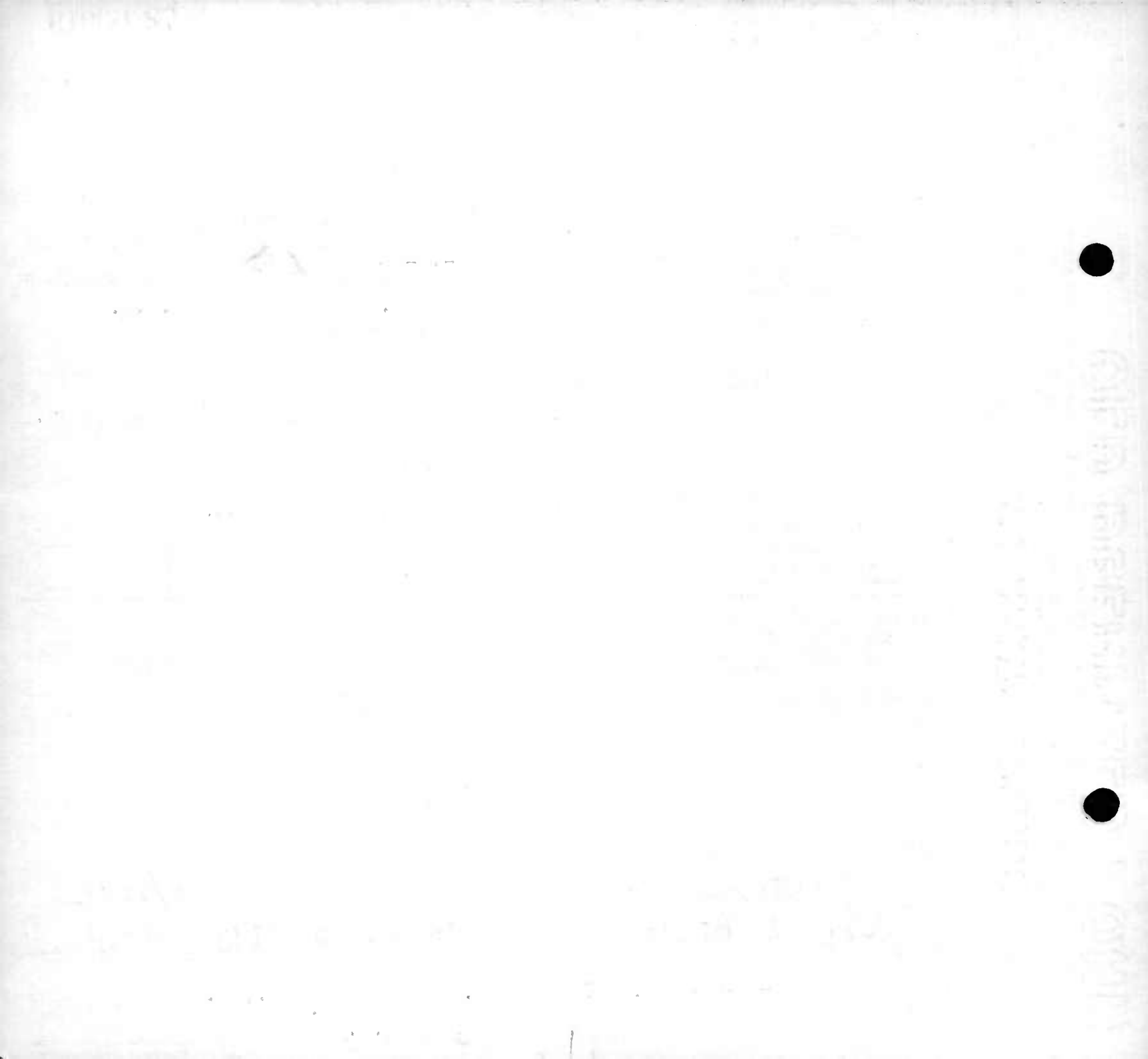
L-620		72 03918		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 03918	
BIRTH NO.				1. NAME OF DECEASED (Type or Print) <i>Joseph Lerch</i>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				2. DATE AND HOUR OF DEATH <i>April 22, 1972</i> 8 P.M.			
FULL NAME OF HOSPITAL OR INSTITUTION <i>Harbor View Nursing Home</i> <i>90</i>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <i>1213 Light St</i>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>101</i>		C. CITY OR TOWN <i>Baltimore</i>	
5. SEX <i>Male</i>		6. RACE <i>White</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>2/26/1899</i> 73	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>B & O Railroad - retired</i>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Germany</i>		12. CITIZEN OF WHAT COUNTRY <i>U.S.A</i>	
13. FATHER'S NAME <i>Thomas Lerch</i>				14. MOTHER'S MAIDEN NAME <i>unk.</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>Unknown</i>		16. SOCIAL SECURITY NO. <i>213-01-6148</i>		17. INFORMANT <i>Chart at Harbor View</i>			
18. <i>1-5-7-9 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Esophageal carcinoma, metastatic</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>2 years</i>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				(B) DUE TO, OR AS A CONSEQUENCE OF:			
(C) DUE TO, OR AS A CONSEQUENCE OF:							
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <i>April 18</i> 19 <i>72</i> to <i>April 22</i> 19 <i>72</i> that (I) (we) last saw the deceased alive on <i>April 22</i> 19 <i>72</i> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <i>Peter H. Rheinstein, MD</i>				23B. DATE SIGNED <i>2/24/1972</i>			
23C. PHYSICIAN'S NAME (Type) <i>PETER H RHEINSTEIN, MD</i>		23D. ADDRESS <i>HARBOR VIEW NURSING CENTER</i>					
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>4/5/72</i>		24C. NAME OF CEMETERY OR CREMATORY <i>Gardens of Faith Cemetery</i>		24D. LOCATION (City, town, or county) (State) <i>Baltimore, Md</i> <i>Zamir's Funeral Hse.</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>APR 24 1972</i>		25B. NAME OF REGISTRAR <i>Robert E. Fisher, Jr.</i>		25C. FUNERAL DIRECTOR <i>Joseph B. Gattano, Jr.</i>		ADDRESS <i>2635 South Connelley</i>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

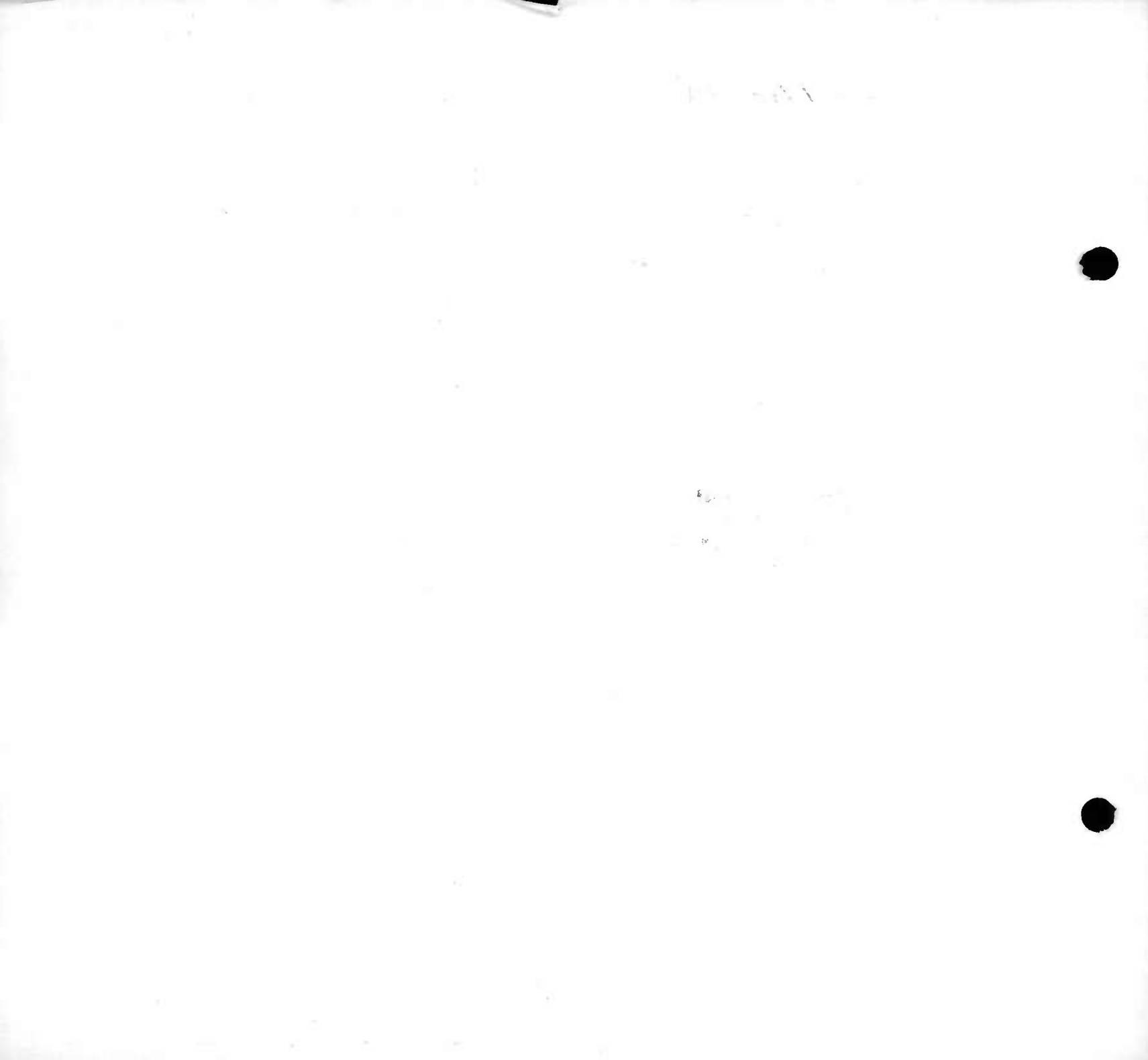
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 03919	
G-600 BIRTH NO. 1. NAME OF DECEASED (Type or Print) ELIZABETH GRAY		72 03919 CERTIFICATE OF DEATH 2. DATE AND HOUR OF DEATH 4-20-72 1:00 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) MARYLAND GENERAL HOSP.		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY 1402 C. CITY OR TOWN BALTO. D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 1435 MYRTLE AVE.			
5. SEX F	6. RACE N	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-17-88	9. AGE (in years last birthday) 83	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Va.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME			
14. MOTHER'S MAIDEN NAME		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no			
16. SOCIAL SECURITY NO. 215165181		17. INFORMANT Henrietta Jackson 3907 Dorchester Rd.			
18. 03871 CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Septicemic inf. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. ASCVD D. mellitus Myoma Uteri					
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 4/20 19 72 to 4/20 19 72 that (I) (we) last saw the deceased alive on 4/20 19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Beltran, M.D.		23B. DATE SIGNED 4/20/72		23C. PHYSICIAN'S NAME (Type) JUAN A. BELTRAN M.D.	
23D. ADDRESS MARYLAND GEN. HOSP.		24A. BURIAL CREMATION, REMOVAL (Specify) Burial			
24B. DATE 4-25-72		24C. NAME OF CEMETERY OR CREMATORY Mt. Calvary Cem.		24D. LOCATION (City, town, or county) (State) Balto., Md.	
25A. DATE REC'D BY HEALTH DEPT. APR 24 1972		25B. NAME OF REGISTRAR John E. Bailey		25C. FUNERAL DIRECTOR V. Bailey	
25D. ADDRESS 1348 Calhoun Street		25E. ADDRESS 1348 Calhoun Street			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

T-623		72 03920		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 03920	
BIRTH NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) VIRGINIA TRUESDALE (Trusdale)				2. DATE AND HOUR OF DEATH 4/23/72 11-25 a.m.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MD. B. COUNTY 2002			
FULL NAME OF HOSPITAL OR INSTITUTION 46 LUTHERAN HOSPITAL				C. CITY OR TOWN BAITIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				E. STREET AND NUMBER 2804 MULBERRY ST.			
5. SEX F	6. RACE N	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 4-29-25	9. AGE (In years last birthday) 46	10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) N.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Victoria Bell		ADDRESS 3436 Childs Court	
18. 410.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) IMMEDIATE CAUSE VENTRICULAR FIBRILLATION DUE TO, OR AS A CONSEQUENCE OF: (B) ACUTE MYOCARDIAL INFARCTION DUE TO, OR AS A CONSEQUENCE OF: (C) ARTERIOSCLEROTIC CORONARY HEART DISEASE			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				POPLITEAL ARTERIAL EMBOLISM (R) LEG			
19A. DATE OF OPERATION 4/22/72		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED POPLITEAL ARTERIAL EMBOLISM		20A. AUTOPSY? (Yes or No) N		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (H) (this hospital) attended the deceased from 3/24 19 72 to 4/23 19 72 that (H) (we) last saw the deceased alive on 4/23 19 72 and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (H) (We) (did) (did not) view the body after death.							
23A. SIGNATURE SEIN LWIN				23B. DATE SIGNED 4/23/72		23C. PHYSICIAN'S NAME (Type) SEIN LWIN	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4-27-72		24C. NAME OF CEMETERY OR CREMATORY Church Cem.		24D. LOCATION (City, town, or county) (State) Charlotte, N.C.	
25A. DATE REC'D BY HEALTH DEPT. APR 24 1972		25B. NAME OF REGISTRAR V. Bailey		25C. FUNERAL DIRECTOR Kelson F. H.		ADDRESS 1848 Calhoun Street	

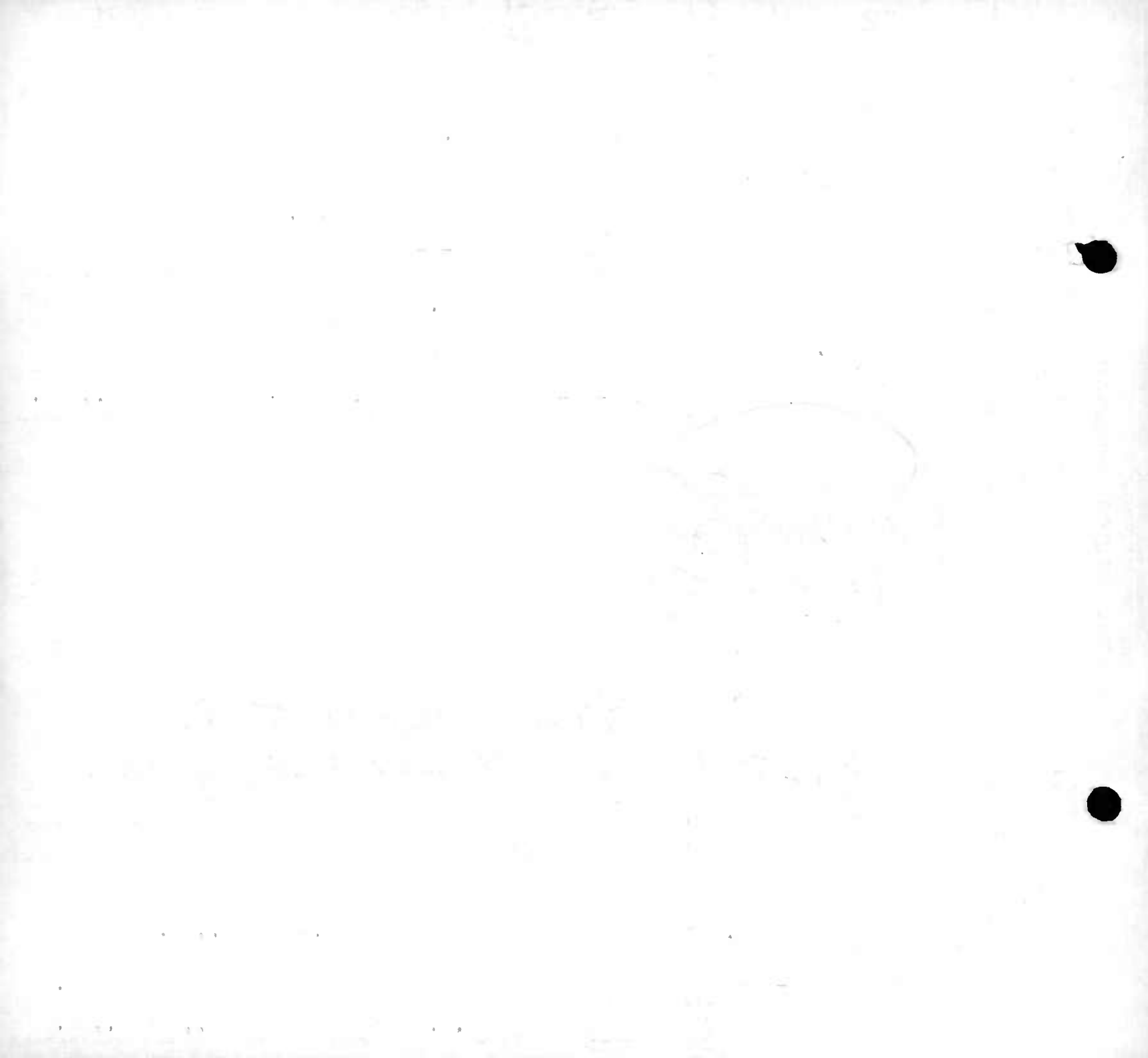


Released on approval by Medical Examiner - Dr. Spitz

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 72 03921		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 03921	
1. NAME OF DECEASED (Type or Print) MATTHEW C. FENTON JR.			2. DATE AND HOUR OF DEATH April 23 1972 5 A.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 00 305 Broxton Road			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY 2712 C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 305 Broxton Rd.		
5. SEX M	6. RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-5-1897	9. AGE (In years last birthday) 74	10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Executive		10B. KIND OF BUSINESS OR INDUSTRY Printing		11. BIRTHPLACE (State or foreign country) Md.	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Matthew C. Fenton		14. MOTHER'S MAIDEN NAME Harriet Thomas	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service Yes WW I & II		16. SOCIAL SECURITY NO. 215-09-0199		17. INFORMANT Matthew C. Fenton III ADDRESS Balto., Md.	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH Overdose - Carbolates (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: ANTECEDENT CAUSES CHIEF OR ASST. MEDICAL EXAMINER giving rise to the above cause (A) stating the UNDERLYING CONDITION last 4-24-72 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 LAST.			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
19A. DATE OF OPERATION 4-24-72			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input checked="" type="checkbox"/>		
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Home			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 305 Broxton Rd. 2712		
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) 4 22 72 ?			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		
21F. HOW DID INJURY OCCUR? Suicide & sleeping pills					
22. I certify that (I) (this hospital) attended the deceased from _____ 19____ to _____ 19____ that (I) (we) last saw the deceased alive on _____ 19____ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Bowman J. Hood MD			23B. DATE SIGNED 4-23-72		
23C. PHYSICIAN'S NAME (Type) Bowman J. Hood MD			23D. ADDRESS 317 Broxton Rd., Balto., Md.		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4-25-72	24C. NAME of CEMETERY or CREMATORY Druid Ridge		24D. LOCATION (City, town, or county) (State) Pikesville Md.
25A. DATE REC'D BY HEALTH DEPT. APR 24 1972		25B. NAME OF REGISTRAR Robert E. Jenkins		25C. FUNERAL DIRECTOR H. W. Jenkins & Sons Co., Balto., Md.	



W-452 72 03922

BALTIMORE CITY HEALTH DEPARTMENT

72 03922

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) JOHN W. WILLIAMSON		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> Month Day Year 4 23 1972 9:25 p	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION Union Memorial Hospital		3. DATE PRONOUNCED DEAD Month Day Year Hour 4 23 1972 9:25 p	
6. SEX male		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
7. RACE negro		C. CITY OR TOWN Balto.	
9. DATE OF BIRTH 5-11-43		10. AGE (In years lost birthday) 28	
11. BIRTHPLACE (State or foreign country) S.C.		12. CITIZEN OF WHAT COUNTRY?	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Burner		14B. KIND OF BUSINESS OR INDUSTRY Shipyard	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		17. SOCIAL SECURITY NO. 251-70-7042	
18. INFORMANT Alease Pressley		ADDRESS 2412 Guilford Ave.	
19. CAUSE OF DEATH Multiple injuries		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(B) DUE TO, OR AS A CONSEQUENCE OF:	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		(C) DUE TO, OR AS A CONSEQUENCE OF:	
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) road	
22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 2630 Harford Rd.		22F. HOW DID INJURY OCCUR? Struck by truck.	
22D. TIME OF INJURY (APPROX.) 4-23-72 9 p m.		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner			
ACTUAL SIGNATURE Russell S. Fisher, M.D.		CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type)		DATE SIGNED 4-24-72	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4-27-72	
24C. NAME OF CEMETERY or CREMATORY Mt Auburn Cemetery		24D. LOCATION (City, town, or county) (State) Balto., Md.	
25A. DATE REC'D BY HEALTH DEPT. APR 24 1972		25B. NAME OF REGISTRAR Robert E. Fisher, M.D.	
25C. FUNERAL DIRECTOR Wm C March		ADDRESS 928 E. North Ave.	

N 9968720003917

5-11-1972 - Letter from the office of the Chief Medical Examiner, Russell S. Fisher, M.D.
Chief Medical Examiner

HRS

CERTIFICATE AMENDED

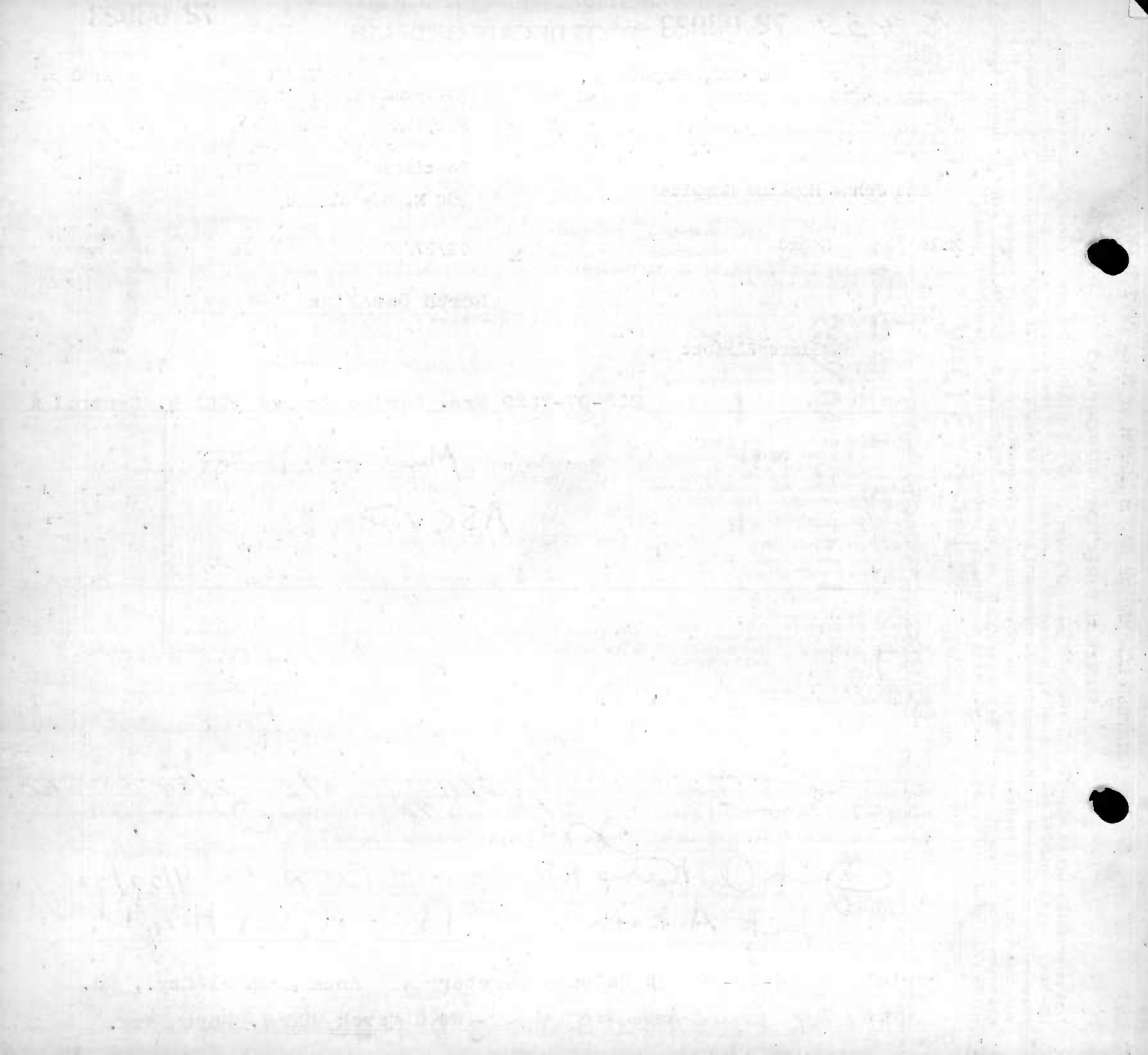
[Handwritten signature]

WALTER FORGE

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Baltimore City Health Department				REG. NO. 72 03923	
E-430 72 03923		CERTIFICATE OF DEATH			
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		ELLIOTT, Chappie E.		4/21/72 1:43 p. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		A. STATE Maryland		B. COUNTY 704	
The Johns Hopkins Hospital		C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER 950 N. Gay Street			
5. SEX Male	6. RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 12/27/04 ?	9. AGE (In years last birthday) 61 ?	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
				North Carolina	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME Wallace Elliott		14. MOTHER'S MAIDEN NAME	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 213-07-7529		17. INFORMANT Mrs. Carine George 1051 N. Central St	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) DISEASE OR CONDITION DIRECTLY LEADING TO DEATH 470.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Myocardial infarction ASCVD (B) DUE TO, OR AS A CONSEQUENCE OF: (C)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notably medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 2/11 1972 to 2/24 1972, that (I) (we) last saw the deceased alive on 2/24 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Jack A. Roth M.D.		23B. DATE SIGNED 4/22/72		23C. PHYSICIAN'S NAME (Type) Jack A. Roth	
23D. ADDRESS Johns Hopkins Hospital		23E. ADDRESS		23F. ADDRESS	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4-25-72		24C. NAME OF CEMETERY or CREMATORY Mt Calvary Cemetery	
24D. LOCATION Anne Arundel Cty., Md.		24E. LOCATION (City, town, or county)		24F. LOCATION (State)	
25A. DATE REC'D BY HEALTH DEPT. APR 24 1972		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR Wm C March 928 E. North Ave.	



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

1. NAME OF DECEASED

(Type or Print)

JUNIUS MYERS (CRATEN)

2. DATE
OF
DEATHKnown ☐
Estimated ☐

Month

Day

Year

Hour

M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL
OR INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)3. DATE
PRONOUNCED DEAD

Month

Day

Year

Hour

M.

April 18, 1972

6:20 P.

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

6. SEX

Male

7. RACE

Negro

8. MARRIED ☐NEVER MARRIED ☐WIDOWED ☐DIVORCED ☐

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☐NO ☐

9. DATE OF BIRTH

6-26-21

10. AGE (In years
lost birthday)

50

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

E. STREET AND NUMBER

1521 Winchester Street

11. BIRTHPLACE (State or foreign country)

South Carolina

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

Craten Myers

14A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Laborer

14B. KIND OF BUSINESS OR INDUSTRY

Construction

15. MOTHER'S MAIDEN NAME

Agnes Sharp

16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

Yes

WWII

17. SOCIAL
SECURITY NO.

250-28-7910

18. INFORMANT

ADDRESS

Edith Myers 418 Patterson Park Av

19.

CAUSE OF DEATH

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH

Cirrhosis of Liver

(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART I (A).

MEDICAL CERTIFICATION

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

no

22A. EXTERNAL CAUSE WAS
UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., In or about
home, farm, factory, street, office bldg., etc.)22C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?22D. TIME (Month) (Day) (Year) (Hour)
OF INJURY (APPROX.)

22E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinionresulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Ronald N. Kornblum, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

4/19/72

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

4-24-72

24C. NAME of CEMETERY or CREMATORY

Mt Auburn Cemetery

24D. LOCATION (City, town, or county)

Balto., Md.

(State)

25A. DATE REC'D BY HEALTH DEPT.

25B. NAME OF REGISTRAR

25C. FUNERAL DIRECTOR

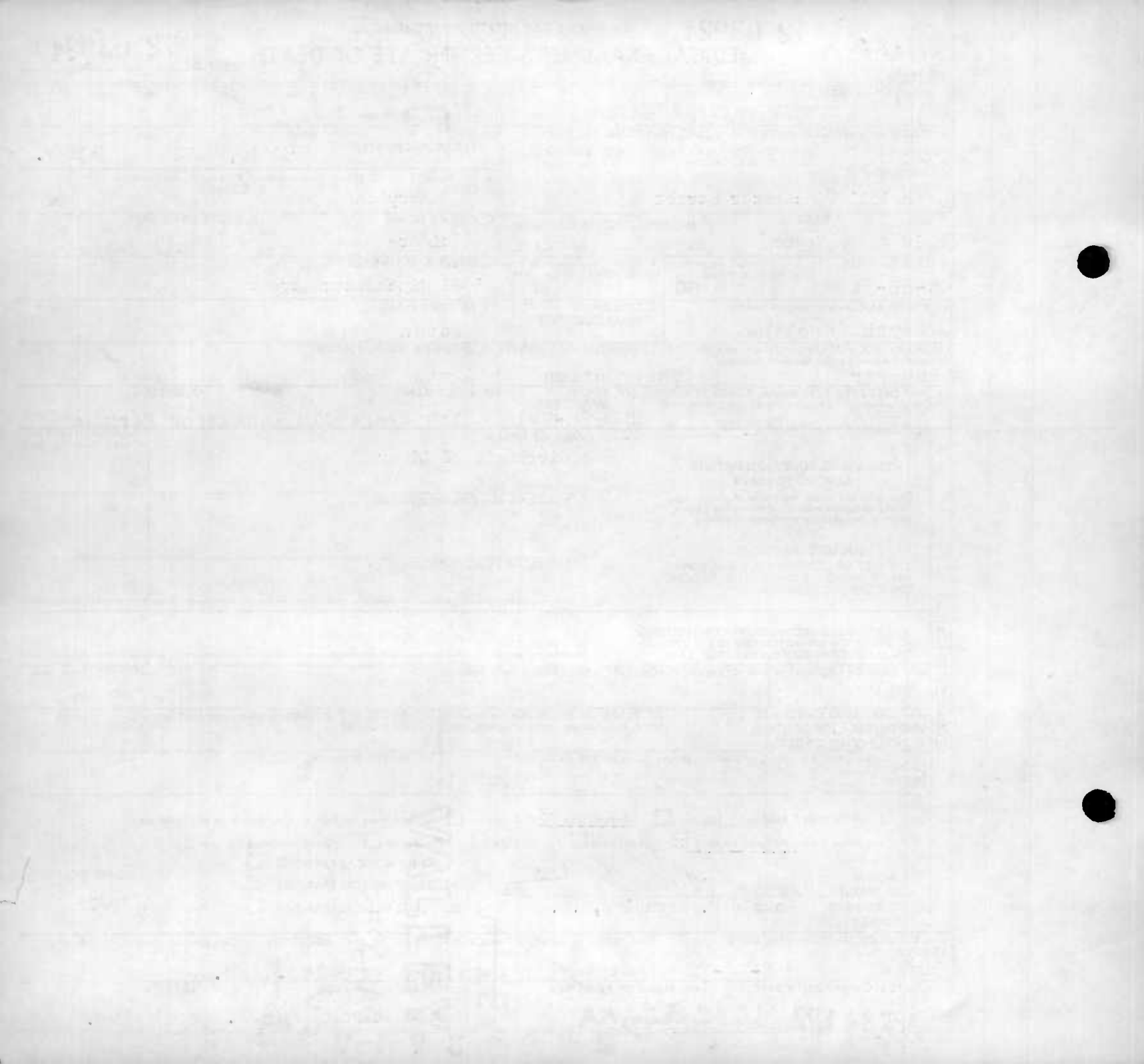
ADDRESS

APR 24 1972

Robert E. Tabor, M.D.

Wm C March

928 E. North Ave.



1. NAME OF DECEASED (Type or Print)		2. DATE OF DEATH		3. DATE PRONOUNCED DEAD		4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		5. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)	
Gary L. Phillips		Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/>		Month 4 Day 22 Year 72		Month 4 Day 22 Year 72		A. STATE Maryland B. COUNTY 2003	
FULL NAME OF HOSPITAL OR INSTITUTION		B. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>		C. CITY OR TOWN		D. INSIDE CITY LIMITS?			
34 Bon Secours Hospital		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
6. SEX		7. RACE		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>		9. DATE OF BIRTH		10. AGE (In years)	
Male		White				JUNE 16, 1954		17	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		15. MOTHER'S MAIDEN NAME	
MARYLAND		U.S.A.		George Hall Phillips SR.		HELPER		Francis Amy Davis	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)		17. SOCIAL SECURITY NO.		18. INFORMANT		19. CAUSE OF DEATH		20. DATE OF OPERATION	
NO		14-62-7257		MOTHER		Gunshot wound of the head		21. AUTOPSY? (Yes or No)	
						(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		yes	
						(B) DUE TO, OR AS A CONSEQUENCE OF:			
						(C) DUE TO, OR AS A CONSEQUENCE OF:			
						OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
						22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
						house		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?	
						22D. TIME OF INJURY (APPROX.)		22E. INJURY OCCURRED	
						4 20 1972 1:10 m.		WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	
						22F. HOW DID INJURY OCCUR?		shot by companion who was "fooling" with gun	
						23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from:			
						Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>			
						Deputy CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED	
						ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		April 23, 1972	
						ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county)		(State)	
BURIAL		4-25-72		LOUDON PARK		BALTIMORE		MD.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		25D. ADDRESS			
APR 25 1972		Robert E. Jansen, M.D.		GEO. L. SCHWAB		2101 FRED'K AVE.			
						BALTO. MD.		21223	

35 0000

x

June 18, 1952

WATKINS

Wm. George Hall Phillips Jr.

Wm. George Hall Phillips Jr.

Wm. George Hall Phillips Jr.

WATKINS

Bureau 4-12-52 Bureau Park Baltimore Md.

Bureau 4-12-52 Bureau Park Baltimore Md.

Bureau 4-12-52 Bureau Park Baltimore Md.

FUNERAL DIRECTOR: IMPORTANT

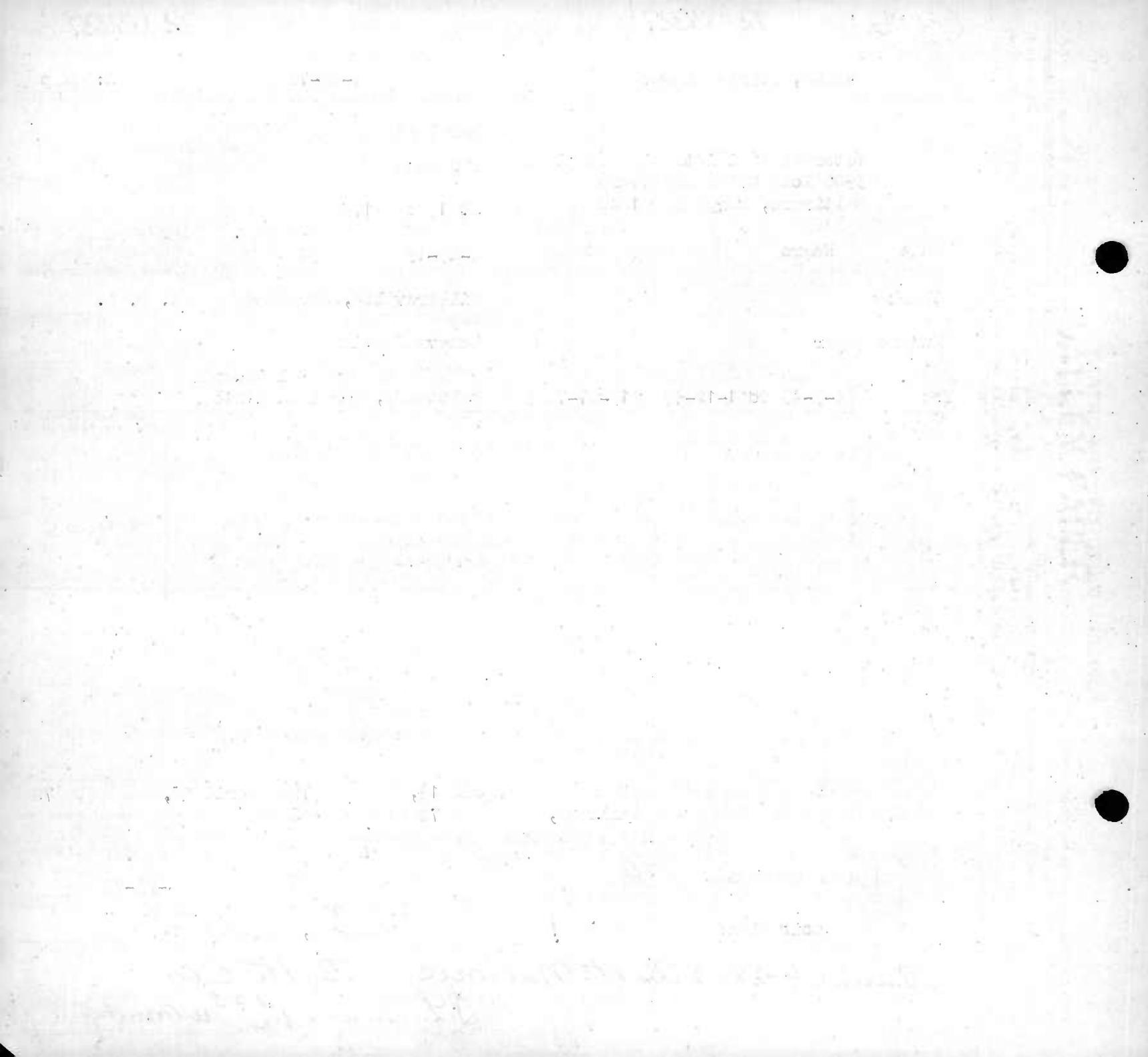
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

<div style="display: flex; justify-content: space-between;"> C-620 72 03926 </div>		<div style="display: flex; justify-content: space-between;"> BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH </div>		REG. NO. 72 03926	
BIRTH NO. MRS. JUANITA CHURCH		1. NAME OF DECEASED (Type or Print) MRS JUANITA CHURCH		2. DATE AND HOUR OF DEATH 4/16/72 10:45 AM	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) UNION MEMORIAL HOSPITAL 335 CALVERT ST. BALTIMORE MD.		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MD B. COUNTY BALTIMORE C. CITY OR TOWN Balt. Md. D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		E. STREET AND NUMBER 2503 Hermosa Ave 21214	
5. SEX FEMALE	6. RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/9/99	9. AGE (in years last birthday) 73	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) N. CAROLINA	
12. CITIZEN OF WHAT COUNTRY? AMERICAN		13. FATHER'S NAME MONROE GREER		14. MOTHER'S MAIDEN NAME SPEARS, MELINDA J.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 232-30-97498		17. INFORMANT ADDRESS Toy Wolf 2503 Hermosa Ave 21214	
18. 56091 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: ? (B) Intestinal obstruction, Anemia, Uremia DUE TO, OR AS A CONSEQUENCE OF: (C)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 18 day.	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 3/3/72		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Intestinal obstruction		20A. AUTOPSY? (Yes or No) <input checked="" type="checkbox"/>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from 3/29/72 to 4/16/72 that (1) (we) last saw the deceased alive on 4/16/72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE V. Vineshindh		DEGREE <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 4/16/72	
23C. PHYSICIAN'S NAME (Type) VIRA VISESHSINDH		23D. ADDRESS UNION MEMORIAL HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4/20/72		24C. NAME OF CEMETERY or CREMATORY Blue Ridge Cemetery	
24D. LOCATION (City, town, or county) (State) Ash Co, North Carolina		25A. DATE REC'D BY HEALTH DEPT. APR 25 1972			
25B. NAME OF REGISTRAR Robert E. Walker, M.D.		25C. FUNERAL DIRECTOR ADDRESS Schwartz, Inc. Balt. Md.			

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

C-260 72 03927		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 03927	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) CAGER, George Eugene		2. DATE AND HOUR OF DEATH 4-22-72 8:30 p.m.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 23 Veterans Administration Hospital 3900 Loch Raven Boulevard Baltimore, Maryland 21218		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE Maryland B. COUNTY AA C. CITY OR TOWN Pasadena D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER Rt 1 Box 317A			
5. SEX Male	6. RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 4-25-15	9. AGE (In years lost birthday) 56	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Millersville, Maryland	
13. FATHER'S NAME Eugene Cager		14. MOTHER'S MAIDEN NAME Geneva Jennings		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes 4-3-43 to 1-12-45		16. SOCIAL SECURITY NO. 215-07-7563		17. INFORMANT VA Hospital Records ADDRESS Baltimore, Maryland 21218	
18. 2381 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) CARDIO-RESPIRATORY ARREST ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: STATUS POST CRANIOTOMY FOR LEFT PARIETO- OCCIPITAL TUMOR		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 8 WEEKS			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION 4-13-72		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED (L) PARIETO OCCIPITAL TUMOR		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that X (this hospital) attended the deceased from April 13, 1972 to April 22, 1972 , that X (we) lost saw the deceased alive on April 22, 1972 and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. X (We) (did) not view the body after death.					
23A. SIGNATURE Nasir Ahmed		23B. DATE SIGNED 4-23-72			
23C. PHYSICIAN'S NAME (Type) Nasir Ahmed		23D. ADDRESS 3900 Loch Raven Boulevard Baltimore, Maryland 21218			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4-28-72		24C. NAME of CEMETERY or CREMATORY Balti National	
24D. LOCATION (City, town, or county) Balti City		24E. LOCATION (State) Balti			
25A. DATE REC'D BY HEALTH DEPT. APR 25 1972		25B. NAME OF REGISTRAR J. L. Brown		25C. FUNERAL DIRECTOR J. L. Brown	
25D. ADDRESS 123 W. Montgomery St.					



G-260

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 72 03928

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Frank A. Gasior

2. DATE
OF
DEATHKnown ☐ Month Day Year Hour
Estimated ☒ 4 23 72 15 A.M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL
OR INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

00 743 S. Curley St.

3. DATE
PRONOUNCED DEADMonth Day Year Hour
4 23 72 15 A.M.

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE MD #21224 B. COUNTY 101

6. SEX

M

7. RACE

Cauc

8. MARRIED ☒ NEVER MARRIED ☐
WIDOWED ☐ DIVORCED ☐

C. CITY OR TOWN

Balto

D. INSIDE CITY LIMITS?

YES ☒ NO ☐

9. DATE OF BIRTH

Dec. 8, 1905

10. AGE (In years
last birthday)

66

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

E. STREET AND NUMBER

743 S. Curley St

11. BIRTHPLACE (State or foreign country)

Baltimore, Maryland

12. CITIZEN OF
WHAT COUNTRY?

U. S. A.

13. FATHER'S NAME

Joseph Gasior

14A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Crane Operator

14B. KIND OF BUSINESS OR INDUSTRY

Standard Oil Co.

15. MOTHER'S MAIDEN NAME

Brigid Drozd

16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

17. SOCIAL
SECURITY NO.

214-01-4455

18. INFORMANT

ADDRESS

Mrs. Margaret Gasior - 743 S. Curley St. #21224

19.

412.4

CAUSE OF DEATH

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, ashenia, etc. It means the disease,
injury or complication which caused death.)

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

Arterio-sclerotic Cardio
Vascular disease.

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART I (A).

20A.

DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

No

22A.

EXTERNAL CAUSE WAS
UNDERLYING ☐ OR CONTRIB-
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg., etc.)22C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?

22D.

TIME (Month) (Day) (Year) (Hour)
OF INJURY
(APPROX.)

22E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Werner H. Spitz

M.D.

CHIEF MEDICAL EXAMINER ☒
ASSISTANT MEDICAL EXAMINER ☐
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

4.23.72

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

4/26/72

24C. NAME of CEMETERY or CREMATORY

St. Stanislaus Cemetery

24D. LOCATION (City, town, or county)

Baltimore, Maryland

(State)

25A. DATE REC'D BY HEALTH DEPT.

APR 25 1972

25B. NAME of REGISTRAR

Robert E. Fisher, M.D.

25C. FUNERAL DIRECTOR

George A. Weber - 705 S. Ann St. #21231

ADDRESS

15 13 12 11 10 9 8 7 6 5 4 3 2 1

Frank Carter

1432 Carney St

M. Case

1432 Carney St

California State
Museum

WALLING

25% 1/2

No

1/2

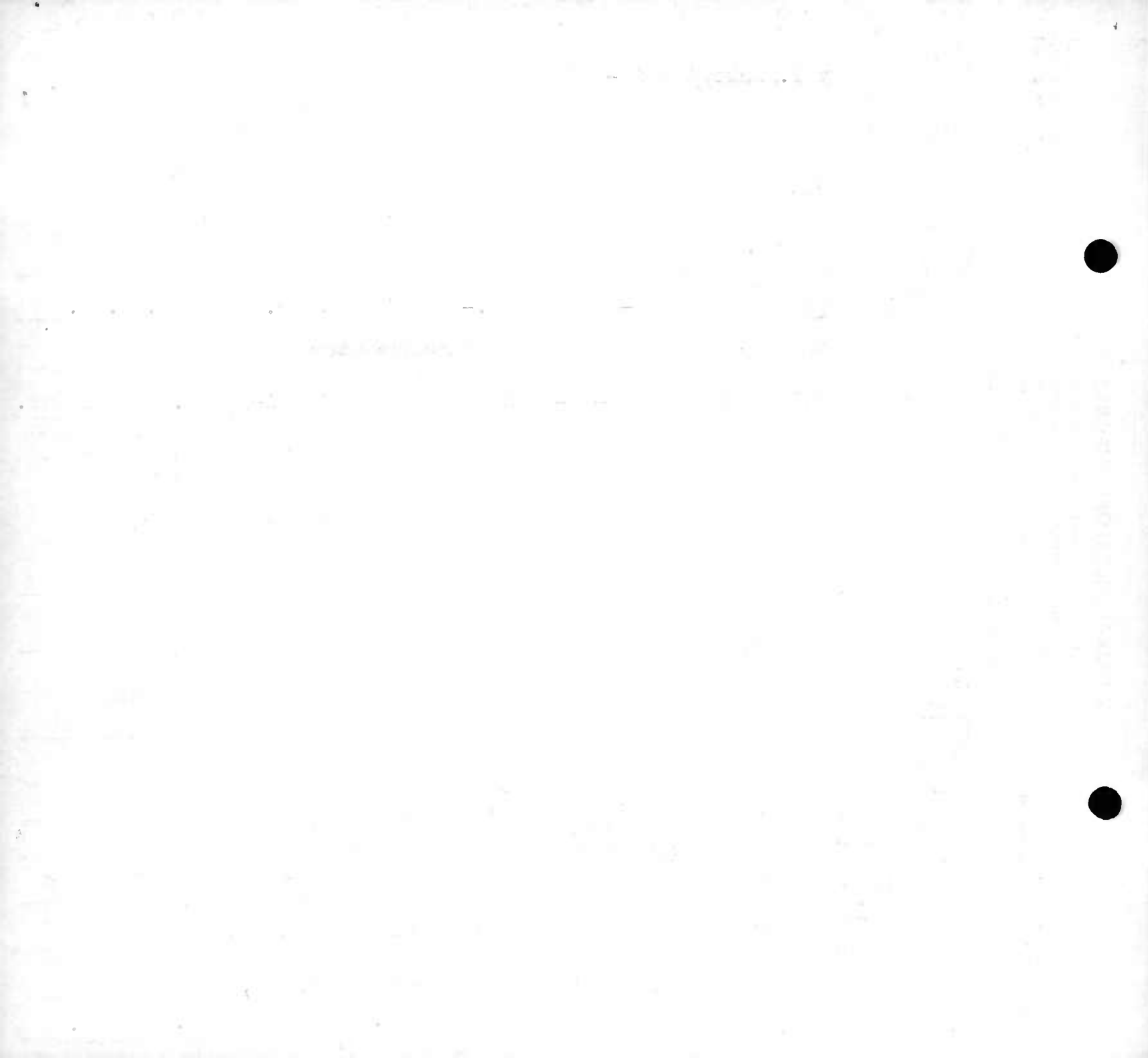
1/2 1/2

1/2 1/2

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <u>M-22072 03929</u>		CITY HEALTH DEPARTMENT		REG. NO. <u>72 03929</u>	
1. NAME OF DECEASED (Type or Print) <u>Harry T. Makowiecki - (Miller)</u>			2. DATE AND HOUR OF DEATH <u>4/24/72</u> <u>7:30 a. m.</u>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <u>33 The Johns Hopkins Hospital</u> IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>#21224</u> <u>102</u>		
			C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER <u>516 S. Decker Avenue</u>		
5. SEX <u>Male</u>	6. RACE <u>Cuac.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12/19/01</u>	9. AGE (in years last birthday) <u>70</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Necktie Cutter</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Coplan-Miller Inc. - Baltimore, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Vincent Makowiecki</u>			14. MOTHER'S MAIDEN NAME <u>Maryanna Gierz</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>Yes</u> <u>World War I</u>		16. SOCIAL SECURITY NO. <u>215-09-2191</u>		17. INFORMANT <u>Stella Makowiecki-516 S. Decker Ave.</u>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>Brain mets 5/10/62</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Undiff. Ca lung</u>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>8/7/72</u>		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>NO</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) I APPROX.		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>4/22/72</u> 19 <u>72</u> to <u>4/24</u> 19 <u>72</u> that (I) (we) last saw the deceased alive on <u>4/24</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Joseph P. Finizio</u>			23B. DATE SIGNED <u>4/24/72</u>		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>
23C. PHYSICIAN'S NAME (Type) <u>Finizio Joseph P.</u>			23D. ADDRESS <u>The Johns Hopkins Hospital</u>		
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>4/27/72</u>		24C. NAME OF CEMETERY OR CREMATORY <u>St. Stanislaus Cemetery Baltimore, Maryland</u>	
24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>		25A. DATE REC'D BY HEALTH DEPT. <u>APR 25 1972</u>			
25B. NAME OF REGISTRAR <u>Robert E. Fisher</u>		25C. FUNERAL DIRECTOR <u>George A. Weber - 705 S. Ann St.</u>			
25D. ADDRESS					



CERTIFICATE OF DEATH

REG. NO. 72 03930

72.03930

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Harry Edward Cook

2. DATE AND HOUR OF DEATH

4/20/72 11⁴⁰ A M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTIONIF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATIONBaltimore City Hospitals
4940 Eastern Avenue
Baltimore, Maryland 212244. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN
Baltimore

D. INSIDE CITY LIMITS?

YES ☒NO ☐

E. STREET AND NUMBER

4821 Orville Ave. 21205

5. SEX

Male

6. RACE

Caucasian

7. MARRIED ☒NEVER MARRIED ☐WIDOWED ☐DIVORCED ☐

8. DATE OF BIRTH

12/6/96

9. AGE (In years
last birthday)

75

If Under 1 Yr.

Months Days Hours Min.

If Under 24 Hrs.

Hours Min.

10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Machinist-retired

10B. KIND OF BUSINESS OR INDUSTRY

Beth. Steel

11. BIRTHPLACE (State or foreign country)

Pennsylvania

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Upton Cook

14. MOTHER'S MAIDEN NAME

-

15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) If yes, give war or dates of service)

no

16. SOCIAL
SECURITY NO.

213-07-9040 A

17. INFORMANT

BCH Records 4940 Eastern Ave.

ADDRESS

21224

18. 4 12 4 1

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, ashenia, etc. It means the disease,
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATHOTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART 1 (A).

19A. DATE OF OPERATION

0

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At
Work ☐Not While
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from April 17, 1972 to April 20, 1972
that (I) (we) last saw the deceased alive on April 20, 1972 and that in (my) (our) opinion death occurred on the date
and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

23A. SIGNATURE

Roland C. Einhorn MD

Attending
Phys. ☐Med.
Director ☐Staff
Phys. ☒

23B. DATE SIGNED

4/20/72

23C. PHYSICIAN'S
NAME (Type)

Roland C. Einhorn M.D.

23D. ADDRESS

Baltimore City Hospitals
4940 Eastern Avenue 2122424A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

4/24/72

24C. NAME of CEMETERY or CREMATORY

Belair Memorial Gardens

24D. LOCATION

(City, town, or county) (State)
Bel Air, Md.

25A. DATE REC'D BY HEALTH DEPT.

APR 25 1972

25B. NAME OF REGISTRAR

25C. FUNERAL DIRECTOR

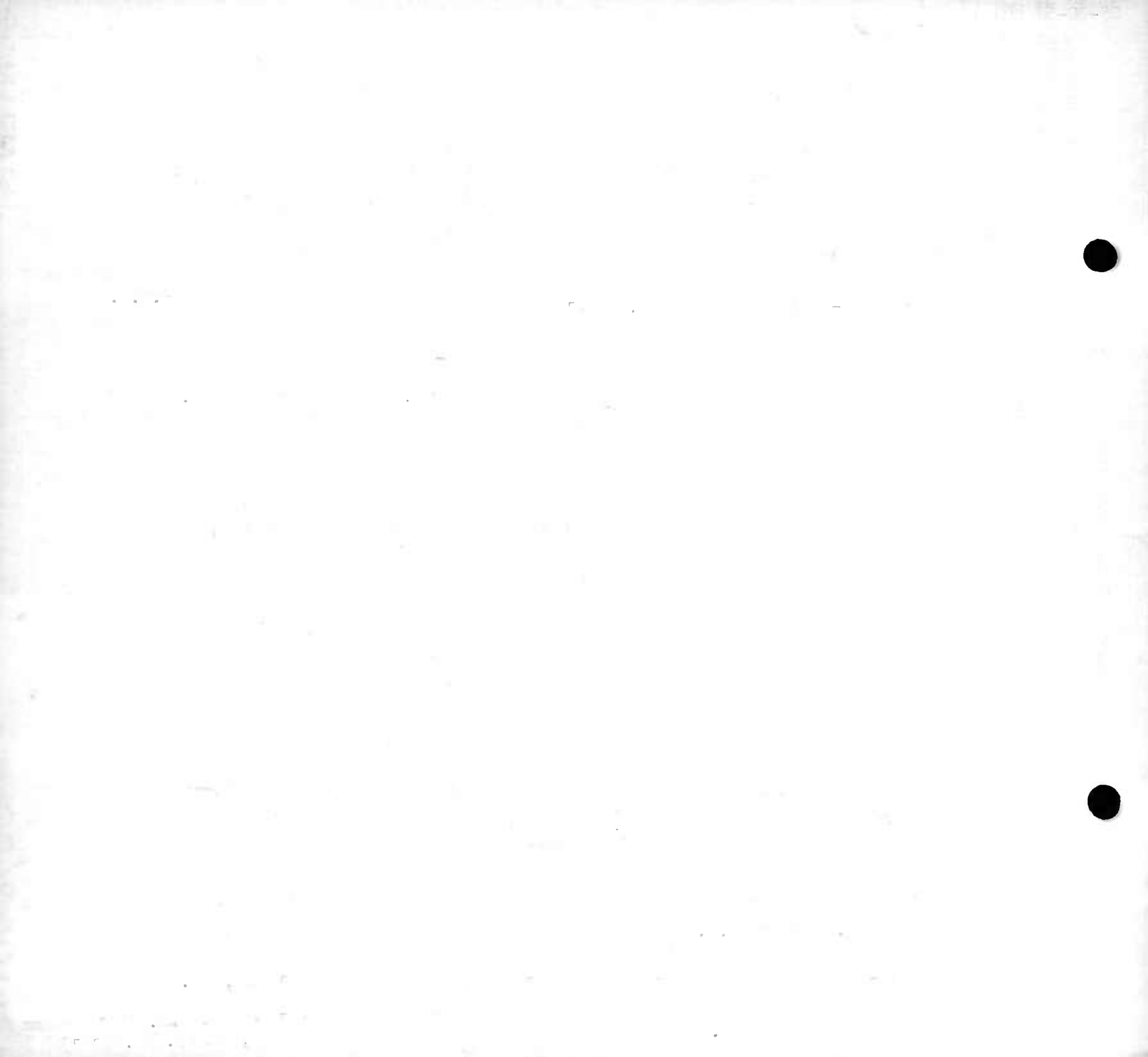
Schimunek Funeral Homes, Inc. 3331 Brehms

ADDRESS

Lano, Balto. Md. 21213

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

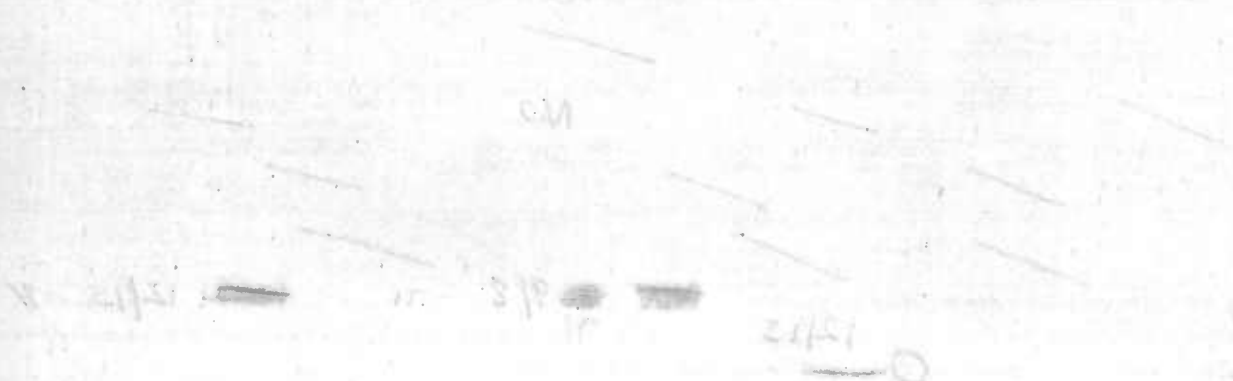


FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				72 03931		REG. NO. 72 03931	
BIRTH NO. 1. NAME OF DECEASED (Type or Print) Marie Schroeder				2. DATE AND HOUR OF DEATH 4/18/72 8 A. M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 00 919 N. Luzerne Ave.				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY 702 5. CITY OR TOWN Balto. 6. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> 7. STREET AND NUMBER 919 N. Luzerne Ave., Balto. Md. 21205			
5. SEX F		6. RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 5/15/91	
9. AGE (In years last birthday) 80		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? USA	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife				10B. KIND OF BUSINESS OR INDUSTRY at home			
13. FATHER'S NAME Gonrad Wittgreffe				14. MOTHER'S MAIDEN NAME Louisa Straub			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no				16. SOCIAL SECURITY NO. 212-05-9488-D		17. INFORMANT Helen Disney (daughter)	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 582X1				(A) IMMEDIATE CAUSE Uremia		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Months	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) CHRONIC RENAL DISEASE Chronic renal disease		years	
(C) CHRONIC URINARY TRACT INFECTION Chronic urinary tract infection				years			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION O		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED /		20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? /	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notably medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) /		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) /			
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour) /		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? /			
22. I certify that (I) (this hospital) attended the deceased from 9/8 1971 to 12/15 1971 that (I) (we) last saw the deceased alive on 12/15 1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (I) (we) (did not) view the body after death.							
23A. SIGNATURE John J. Elmann R.O.				23B. DATE SIGNED 4-18-72			
23C. PHYSICIAN'S NAME (Type) Dr. John Mann				23D. ADDRESS Johns Hopkins Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4/22/72		24C. NAME OF CEMETERY OR CREMATORY Baltimore Cemetery		24D. LOCATION (City, town, or county) (State) Balto. Md.	
25A. DATE REC'D BY HEALTH DEPT. APR 25 1972		25B. NAME OF REGISTRAR Robert E. Taylor, R.O.		25C. FUNERAL DIRECTOR Schimunek Funeral Homes, Inc.		ADDRESS 3331 Brehms Lane, Balto. Md. 21213	

Chronic (long) disease
Chronic (short) disease



4-18-75

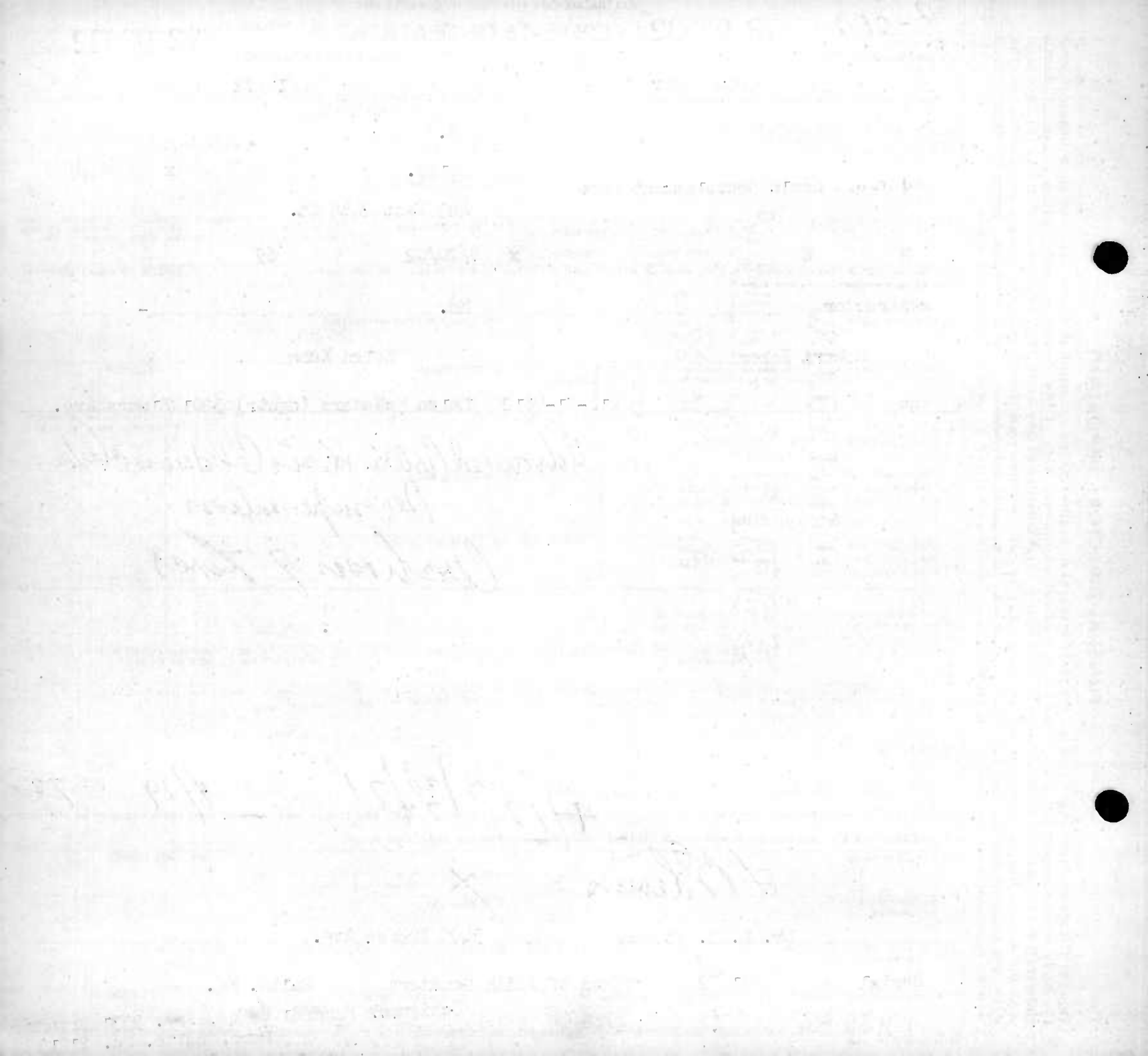
X

John F. Kennedy

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

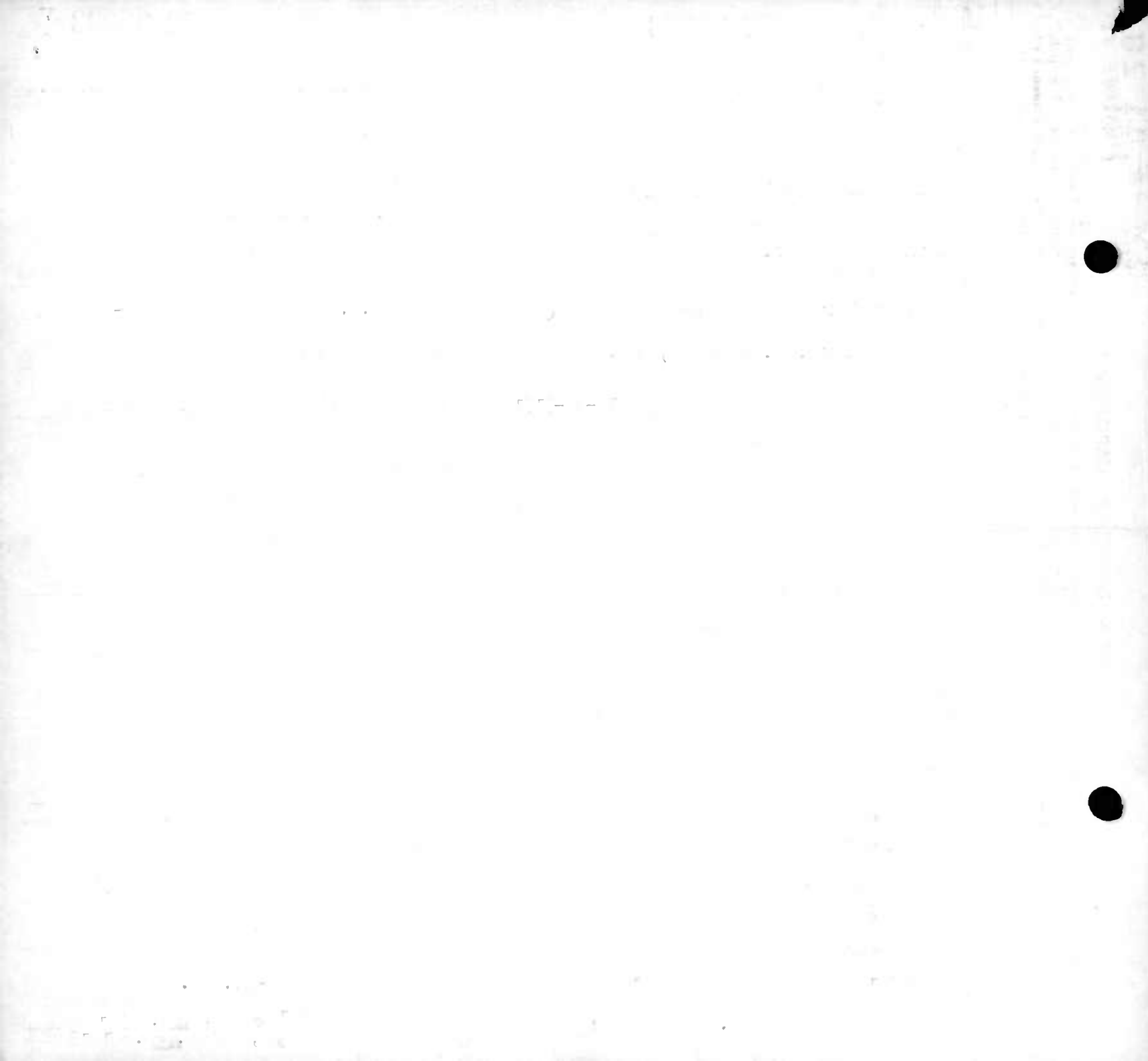
Baltimore City Health Department				REG. NO. 72 03932	
B-260 72 03932 CERTIFICATE OF DEATH		BIRTH NO. 1. NAME OF DECEASED (Type or Print) John Baker			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 90 Gould Convalescent Home		2. DATE AND HOUR OF DEATH 4/19/72 M. 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE Md. B. COUNTY 1204 C. CITY OR TOWN Balto. D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 443 East 24th St.			
5. SEX M	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH 8/20/02	9. AGE (In years last birthday) 69
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) contractor		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Md.	
13. FATHER'S NAME Robert Baker		14. MOTHER'S MAIDEN NAME Helen Kehm			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 214-01-9612		17. INFORMANT Helen McNamara (dghtr)	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. 412.4 I Advanced Arteriosclerotic C.V. Disease & Cornea Decompensation Cirrhosis of Liver		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION O		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 3/30/71 to 4/19 19 72 that (I) (we) last saw the deceased alive on 4/17 19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE J. B. Stevens				23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) Dr. I. B. Stevens				23D. ADDRESS 3400 Erdman Ave.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4/27/72		24C. NAME of CEMETERY or CREMATORY Gardens of Faith Cemetery	
24D. LOCATION (City, town, or county) (State) Balto. Md.		25A. DATE REC'D BY HEALTH DEPT. APR 25 1972			
25B. NAME OF REGISTRAR Robert E. J. J. J.		25C. FUNERAL DIRECTOR Schimunek Funeral Homes, Inc.			
25D. ADDRESS 3331 Brehms Lane, Balto. Md. 21213					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				72 03933		REG. NO. 72 03933	
BIRTH NO. J-630				72 03933			
1. NAME OF DECEASED (Type or Print) JIROUT, Joseph				2. DATE AND HOUR OF DEATH 4/19/72 3:30 a. m.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) The Johns Hopkins Hospital				A. STATE Maryland B. COUNTY 703			
				C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER 2103 E. Madison Street			
5. SEX Male	6. RACE Cauc.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/16/13	9. AGE (In years last birthday) 58	If Under 1 Yr. Months	If Under 24 Hrs. Days	If Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Chauffeur			10B. KIND OF BUSINESS OR INDUSTRY Jones Motor Lines		11. BIRTHPLACE (State or foreign country) N.J.		12. CITIZEN OF WHAT COUNTRY? -
13. FATHER'S NAME Joseph J. Jirout, Sr.				14. MOTHER'S MAIDEN NAME Marie Ruzicka			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 216-05-3131		17. INFORMANT Anna Jirout (wife)		ADDRESS same as above	
18. 162.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: 1. CLT (B) OAT CELL CA Lung DUE TO, OR AS A CONSEQUENCE OF: (C) _____ DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION 21		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from April 13 19 72 to April 9 19 72 that (I) (we) last saw the deceased alive on April 14 19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE J. P. Fazio				23B. DATE SIGNED 4/19/72		23C. PHYSICIAN'S NAME (Type) J. P. Fazio	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4/24/72		24C. NAME OF CEMETERY OR CREMATORY Holy Redeemer Cemetery		24D. LOCATION (City, town, or county) (State) Barto. Md.	
25A. DATE REC'D BY HEALTH DEPT. APR 25 1972		25B. NAME OF REGISTRAR Barbara J. ...		25C. FUNERAL DIRECTOR Schilmunek Funeral Homes, Inc.		ADDRESS 3331 Brehms Lane, Balto. Md. 21213	



FUNERAL DIRECTOR: IMPORTANT

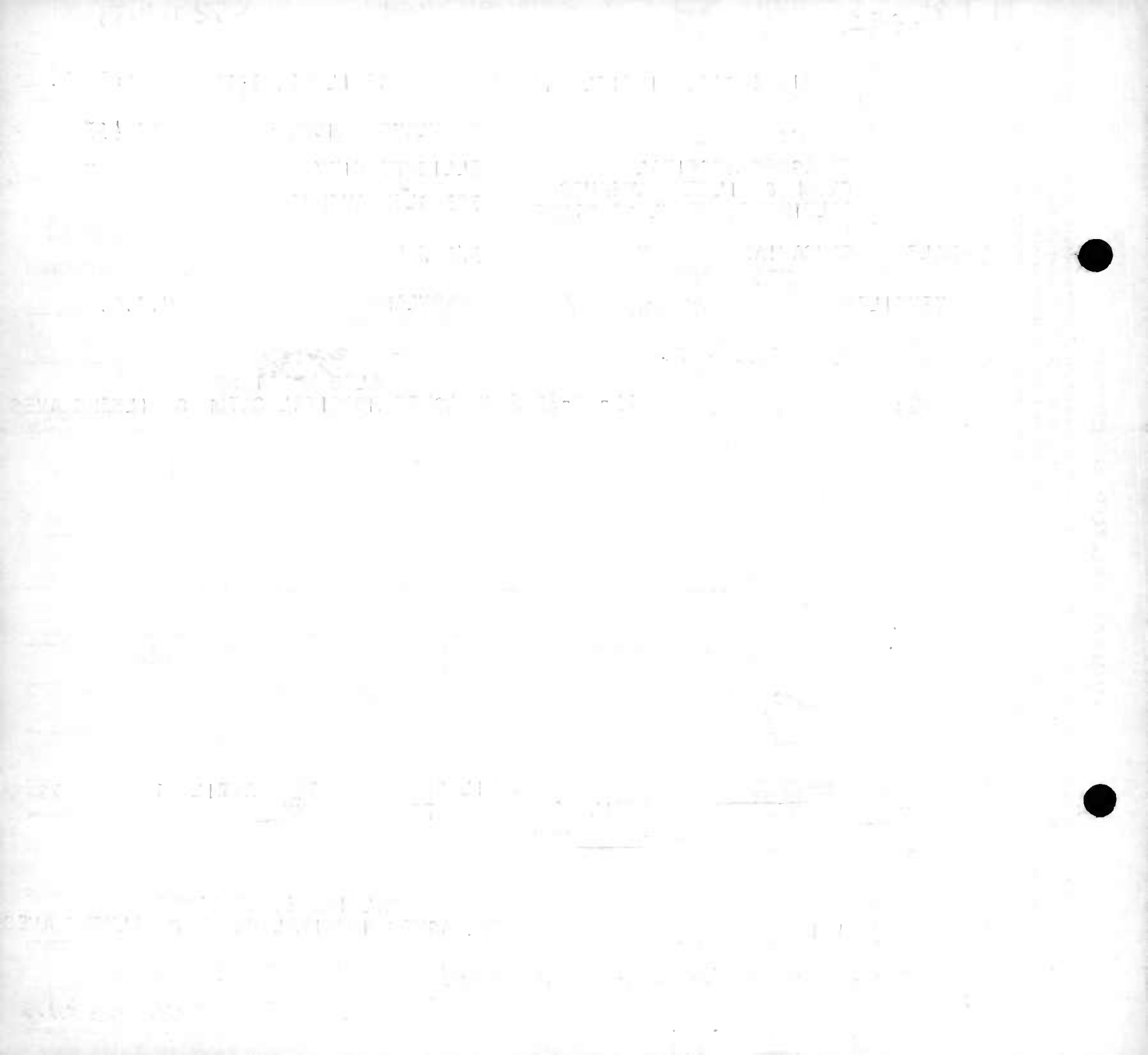
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

S-160		72 03934		BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		X REG. NO. 72 03934			
BIRTH NO.				1. NAME OF DECEASED (Type or Print) SCHAFER NETTIE				2. DATE AND HOUR OF DEATH 4/22/72 1:30 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY AA				5200			
FULL NAME OF HOSPITAL OR INSTITUTION South Baltimore General Hospital				C. CITY OR TOWN Baltimore				D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			
E. STREET AND NUMBER 43 501 Doris Ave				6. RACE W				7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. SEX F				8. DATE OF BIRTH 8.20.92				9. AGE (In years lost birthday) 79			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10B. KIND OF BUSINESS OR INDUSTRY -				11. BIRTHPLACE (State or foreign country) Illinois			
12. CITIZEN OF WHAT COUNTRY? U.S.A				13. FATHER'S NAME Jacob Schafer				14. MOTHER'S MAIDEN NAME Marie			
15. Was Deceased Ever in U.S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. 213-01-89848				17. INFORMANT Eduard F. Schafer			
ADDRESS 501 Doris Ave 21225				18. 410.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Anterior Myocardial Infarction E arrhythmia and cardiac failure Coronary vascular disease				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). nil				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Anterior Myocardial Infarction E arrhythmia and cardiac failure				(B) Coronary vascular disease DUE TO, OR AS A CONSEQUENCE OF: -			
(C) -				19A. DATE OF OPERATION nil				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED nil			
20A. AUTOPSY? (Yes or No) NO				20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? -				21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner) nil			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) nil				21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) nil				21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) nil			
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> nil				21F. HOW DID INJURY OCCUR? nil				22. I certify that (I)-(this hospital) attended the deceased from 4/20/1972 to 4/22/1972 , that (I) (we) last saw the deceased alive on 4/22/1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE R. Sirithara				23B. DATE SIGNED 4/22/72				23C. PHYSICIAN'S NAME (Type) SIRITHARA			
23D. ADDRESS South Baltimore General Hospital				24A. BURIAL CREMATION, REMOVAL (Specify) Burial				24B. DATE 4/25/72			
24C. NAME OF CEMETERY or CREMATORY Glen Haven Cemetery				24D. LOCATION (City, town, or county) (State) Glen Burnie Md. 21061				25A. DATE REC'D BY HEALTH DEPT. APR 25 1972			
25B. NAME OF REGISTRAR Robert E. [unclear]				25C. FUNERAL DIRECTOR McCully Funeral Home				ADDRESS 237 Patapsco Ave 21225			

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

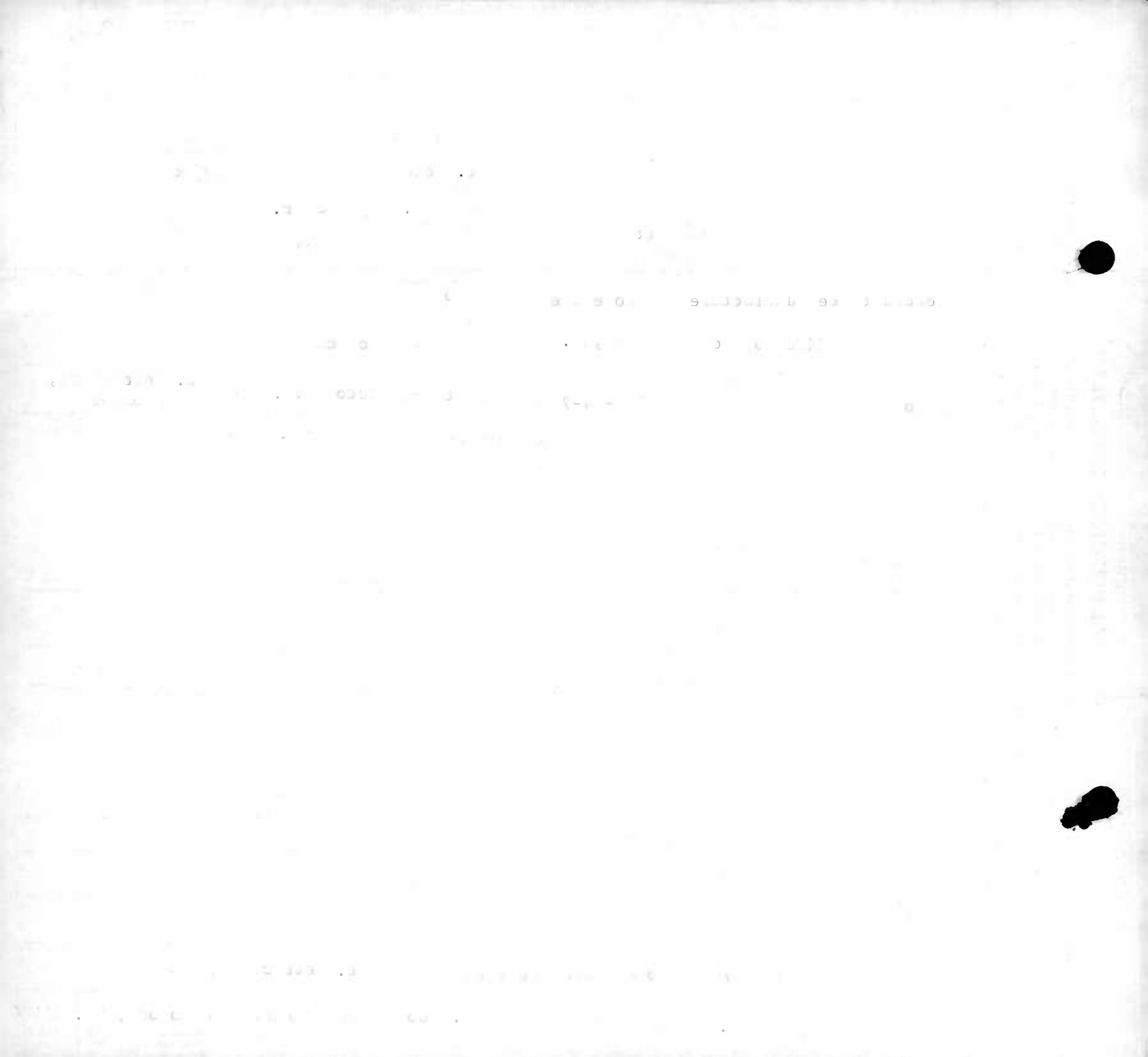
Baltimore City Health Department				REG. NO. 72 03935	
B-352 72 03935 CERTIFICATE OF DEATH		72 03935			
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
BIDDINGER, WINFIELD HENRY		APRIL 21, 1972		6:50 A. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION 40 ST AGNES HOSPITAL CATON & WILKENS AVENUES BALTIMORE, MARYLAND 21229		A. STATE MARYLAND B. COUNTY HOWARD 6300 210438			
		C. CITY OR TOWN ELLCOTT CITY		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
		E. STREET AND NUMBER 793 GLEN AVENUE			
5. SEX MALE	6. RACE CAUCASIAN	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 03/30/84	9. AGE in years (last birthday) 88	10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) TEXTILER		10B. KIND OF BUSINESS OR INDUSTRY Woolen Mill		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY U.S.A.		13. FATHER'S NAME Ellwood Biddinger			
14. MOTHER'S MAIDEN NAME SARA Hobbs		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			
16. SOCIAL SECURITY NO. 213-09-6306		17. INFORMANT BALTO MD 21229 ST AGNES HOSPITAL CATON & WILKENS AVES			
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Cerebro-vascular ACCIDENT.					
(B) DUE TO, OR AS A CONSEQUENCE OF:					
(C) DUE TO, OR AS A CONSEQUENCE OF:					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (X) (this hospital) attended the deceased from APRIL 20 19 72 to APRIL 21 19 72 that (X) (we) last saw the deceased alive on APRIL 21 19 72 and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (X) (X) view the body after death.					
23A. SIGNATURE M. John		23B. DATE SIGNED 4/21/72		23C. PHYSICIAN'S NAME (Type) M JOHN	
23D. ADDRESS BALTIMORE, MD 21229 ST. AGNES HOSPITAL; CATON & WILKENS AVES					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4-24-72		24C. NAME of CEMETERY or CREMATORY Gold Shepherd	
24D. LOCATION Ellicott City and					
25A. DATE REC'D BY HEALTH DEPT. APR 25 1972		25B. NAME OF REGISTRAR Black F. H.		25C. FUNERAL DIRECTOR Ellicott City, MD 21043	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>72 03936</u>	
<div style="display: flex; justify-content: space-between;"> <u>W-452</u> 72 03936 CERTIFICATE OF DEATH </div>					
<div style="display: flex; justify-content: space-between;"> BIRTH NO. <u>1</u> 1. NAME OF DECEASED (Type or Print) <u>Williams, Horace Jr.</u> 2. DATE AND HOUR OF DEATH <u>4/21/72 10:45 A.M.</u> </div>					
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>Maryland General Hospital</u> <u>48</u>			4. USUAL RESIDENCE (Where deceased lived, if institutions residence before admission) A. STATE <u>Florida</u> B. CITY OR TOWN <u>St. Petersburg</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>2650 W. Bay Isle Dr.</u>		
5. SEX <u>Male</u>	6. RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5/3/16</u>	9. AGE (In years lost birthday) <u>55</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Merchant Ice Manufacture</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Wholesale</u>		11. BIRTHPLACE (State or foreign country) <u>Florida</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			13. FATHER'S NAME <u>XXXXX Horace Williams, Sr.</u>		
14. MOTHER'S MAIDEN NAME <u>Ida Weller</u>			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		
16. SOCIAL SECURITY NO. <u>265-14-7958 A</u>			17. INFORMANT <u>Wilhelm-Thurston F.H. Inc</u> ADDRESS <u>St. Petersburg, Florida</u>		
18. <u>162.1 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>Bronchogenic carcinoma</u> CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 19A. DATE OF OPERATION <u>2</u> 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Ca Right Lung</u> 20A. AUTOPSY? (Yes or No) <u>Yes</u> 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>Yes</u>					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR	
22. I certify that (I) (this hospital) attended the deceased from <u>19</u> to <u>19</u> that (I) (we) lost saw the deceased alive on <u>19</u> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Michael J. Faulhaber</u> DEGREE <u>MD</u>			23B. DATE SIGNED <u>4/21/72</u>		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>
23C. PHYSICIAN'S NAME (Type)			23D. ADDRESS		
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>4/25/72</u>	24C. NAME of CEMETERY or CREMATORY <u>Royal Palm Cemetery</u>		24D. LOCATION (City, town, or county) (State) <u>St. Petersburg, Florida</u>
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR <u>Wm. Cook-Brooks</u>		25C. FUNERAL DIRECTOR ADDRESS <u>Towson Inc Towson, Md. 21204</u>	



1

C-260 72 03937 BALTIMORE CITY HEALTH DEPARTMENT
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH REG. NO. 72 03937

1. NAME OF DECEASED (Type or Print) ALBERT RICHARD CHESSE		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 35 Church Home & Hospital		3. DATE PRONOUNCED DEAD Month Day Year Hour 4 17 1972 1:15 a M.	
6. SEX male		7. RACE white	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Balto.	
9. DATE OF BIRTH 2-3-1954		10. AGE (In years last birthday) 18	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME ALBERT R. CHESSE		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PAINTER	
15. MOTHER'S MAIDEN NAME MILDRED PIERCY		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) NO	
17. SOCIAL SECURITY NO. 218 58 4509		18. INFORMANT ALBERT CHESSE 625 S. BELNORD AVE	
19. CAUSE OF DEATH 480X, 304.1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		CAUSE OF DEATH Bronchopneumonia complicating alcohol and methadone addiction (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:	
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) yes			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?		22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Russell S. Fisher, M.D. CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> EXAMINER'S NAME (Type) Russell S. Fisher, M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 4-17-72			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4/20/72	
24C. NAME OF CEMETERY or CREMATORY GARDENS OF FAITH		24D. LOCATION (City, town, or county) (State) BALTIMORE MARYLAND	
25A. DATE REC'D BY HEALTH DEPT. APR 25 1972		25B. NAME OF REGISTRAR Robert E. Fisher, M.D.	
25C. FUNERAL DIRECTOR John M. Weber & Son, Inc.		25D. ADDRESS 401 S. Chester St.	

5-16-1972 - Completion of cause of death on a pending medical examiner death certificate

Russell S. Fisher, M.D.

HRS

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

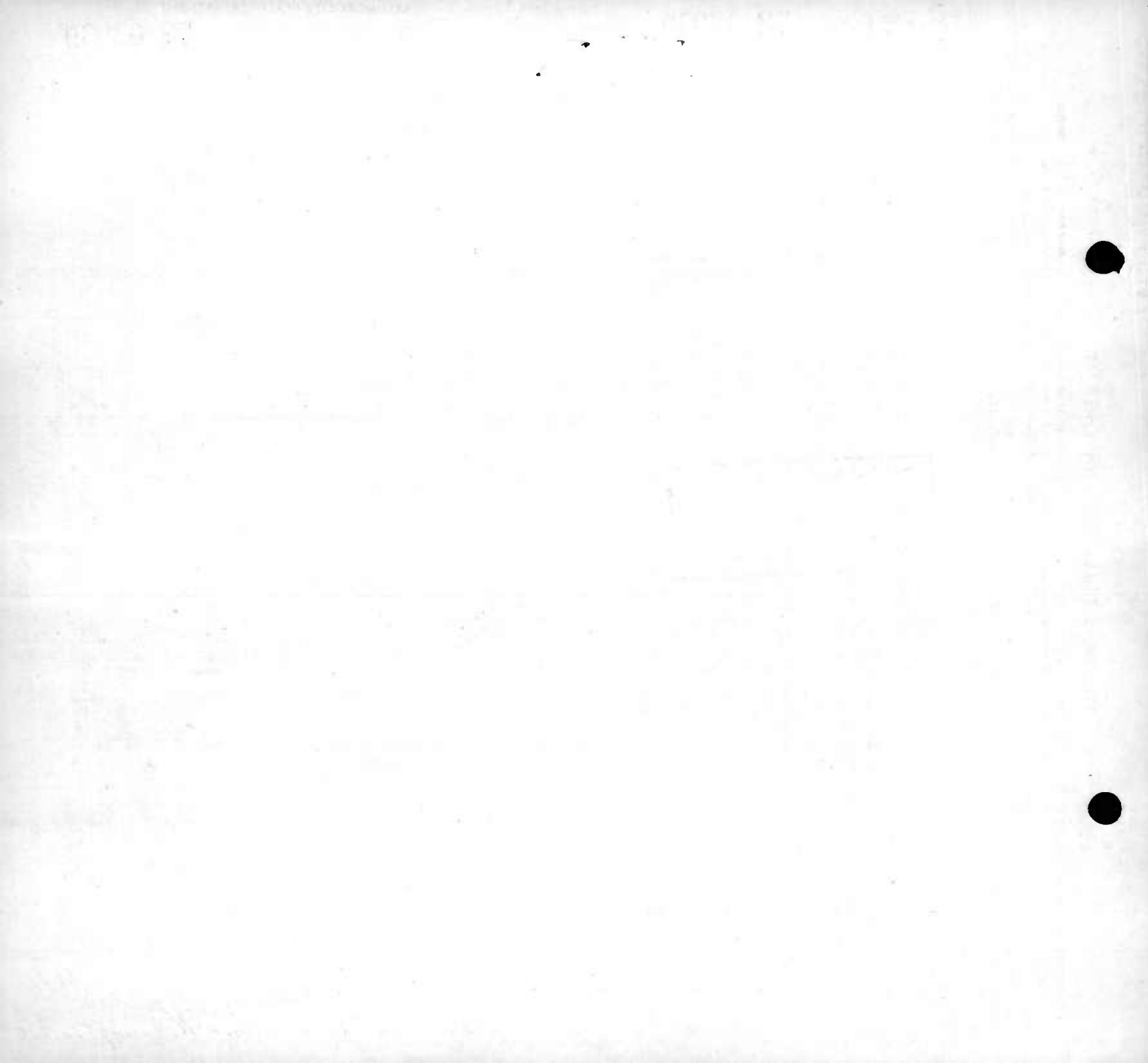
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 03938	
S-363 72 03938				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) WILLIAM EDGAR Street		2. DATE AND HOUR OF DEATH 4/23/72 12¹⁰/A M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Md. B. COUNTY 103			
FULL NAME OF HOSPITAL OR INSTITUTION 49 NCGH		C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX MALE		6. RACE CAUC.		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MACHINIST-COAL MINER		10B. KIND OF BUSINESS OR INDUSTRY		8. DATE OF BIRTH 9/30/09	
13. FATHER'S NAME JAMES PARK STREET		14. MOTHER'S MAIDEN NAME DAMIE THORNTON		9. AGE (In years last birthday) 62 YRS.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 235-10-6307		17. INFORMANT (SON) JAMES WILLIAM STREET	
18. 4-1-72 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Acute myocardial infarct		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Severe atherosclerosis = occlusion coronary art. heart		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. old MI		(B) DUE TO, OR AS A CONSEQUENCE OF: Severe ch. lung disease (black lung)			
		(C) Chor. Pulmonaris			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). gastric ulcer					
19A. DATE OF OPERATION 2-2-72		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY (Yes or No) Yes	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Approx.) 11:00 AM		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from _____ 19____ to _____ 19____ that (I) (we) last saw the deceased alive on _____ 19____ and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Edward Sherrer				23B. DATE SIGNED 24 Apr 72	
23C. PHYSICIAN'S NAME (Type) Edward Sherrer				23D. ADDRESS N. Char. Gen Hosp.	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 4-25-72		24C. NAME OF CEMETERY or CREMATORY HOLLY HILLS CEM.	
24D. LOCATION BALTIMORE		24E. STATE MARYLAND			
25A. DATE REC'D BY HEALTH DEPT. APR 25 1972		25B. NAME OF REGISTRAR Robert E. Fisher, M.D.		25C. FUNERAL DIRECTOR JOHN M. WEBER & SONS INC 401 S. CHESTER ST.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-360 72 03939		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 03939
CERTIFICATE OF DEATH				
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>Corheda White Better</i>		2. DATE AND HOUR OF DEATH <i>4-23-72 1:35 A. M.</i>
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <i>Lutheran Hosp.</i>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Md.</i> B. COUNTY <i>1605</i>		
5. SEX <i>Female</i> 6. RACE <i>NEGRO</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>9-18-09</i> 9. AGE (In years last birthday) <i>62</i>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>teacher</i>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Md.</i>
13. FATHER'S NAME <i>George White</i>		14. MOTHER'S MAIDEN NAME <i>Maggie Locks</i>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <i>James R. Better</i> ADDRESS <i>same</i>
18. <i>410.91</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH NOT A MEDICAL EXAMINER'S CASE (This does not mean the cause is e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) <i>Coronary Occlusion</i> ANTECEDENT CAUSES <i>Myocardial Infarction</i> DECEASED OR ASSISTED MEDICAL EXAMINER <i>Underlying condition</i>		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Coronary Occlusion</i> (B) DUE TO, OR AS A CONSEQUENCE OF: <i>Myocardial Infarction</i> (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>one week</i>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <i>Sudden death. Medical examiner reported for this</i>				
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>no</i>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from <i>Apr 18, 1972</i> to <i>Apr 18, 1972</i> that (I) (we) last saw the deceased alive on <i>Apr 18, 1972</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <i>George Mc Donald</i>		23B. DATE SIGNED <i>4/25/72</i>		23C. PHYSICIAN'S NAME (Type) <i>George Mc Donald</i>
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>4-27-72</i>		24C. NAME of CEMETERY or CREMATORY <i>Mt. Auburn Cem.</i>
25A. DATE REC'D BY HEALTH DEPT. <i>APR 25 1972</i>		25B. NAME OF REGISTRAR <i>Robert E. Fisher</i>		25C. FUNERAL DIRECTOR <i>Sullivan Funeral Home</i> ADDRESS <i>1011-13 N. Arlington Ave</i>



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <u>A-352</u>				BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. <u>72 03910</u>	
1. NAME OF DECEASED (Type or Print) <u>James Adams</u>				2. DATE AND HOUR OF DEATH <u>4/24/72</u> <u>12-42a.m.</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <u>Lutheran Hospital of Md.</u>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE <u>md.</u>		B. COUNTY <u>909</u>	
				C. CITY OR TOWN <u>Balti</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <u>1417 N. Central Ave</u>			
5. SEX <u>male</u>	6. RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-8-1896</u>		9. AGE (In years last birthday) <u>76 yrs</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Labourer</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>		11. BIRTHPLACE (State or foreign country) <u>S. Carolina</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Sam Adams</u>				14. MOTHER'S MAIDEN NAME <u>Dora Wallace</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no, or unknown) (If yes, give war or doles of service) <u>No</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Chart</u>			
18. <u>4/19/72</u> CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)				(A) IMMEDIATE CAUSE <u>CRIME ARREST</u> DUE TO, OR AS A CONSEQUENCE OF:			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) <u>MYOCARDIAL INFARCT</u> DUE TO, OR AS A CONSEQUENCE OF:			
				(C) <u>CHF, ASCVD</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that <u>Dr</u> (this hospital) attended the deceased from <u>4/21/72</u> to <u>4/24/72</u> that <u>Dr</u> (we) last saw the deceased alive on <u>4/24/72</u> and that in <u>my</u> (our) opinion death occurred on the date and hour and from the causes stated above. <u>I</u> (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>John Lwin</u>				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>4/24/72</u>	
23C. PHYSICIAN'S NAME (Type) <u>John Lwin</u>				23D. ADDRESS <u>LUTHERAN HOSPITAL</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>4-29-72</u>		24C. NAME of CEMETERY or CREMATORY <u>Int. Calvary Cem</u>		24D. LOCATION (City, town, or county) (State) <u>A. A. County, Md.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>APR 25 1972</u>		25B. NAME OF REGISTRAR <u>John Lwin</u>		25C. FUNERAL DIRECTOR <u>Whitton Collickson</u> ADDRESS <u>1129 N. Caroline St</u>			



BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Louis C. Jones

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

00 511 E. 21st Street

6. SEX

Male

7. RACE

Colored

8. MARRIED ☐ NEVER MARRIED ☒WIDOWED ☐ DIVORCED ☐

9. DATE OF BIRTH

3/15/1905

10. AGE (In years last birthday)

67

11. Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.

11. BIRTHPLACE (State or foreign country)

Tillery, N.C.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

MOSES JONES

14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

retired

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

Lula Johnson

16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

no

17. SOCIAL SECURITY NO.

18. INFORMANT

Daisy Jones - 511 E. 21 St.

ADDRESS

19. 412.4

CAUSE OF DEATH

Arteriosclerotic cardio-vascular disease.

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).

20A. DATE OF OPERATION 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

no

22A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?

22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

22E. INJURY OCCURRED

WHILE AT WORK ☐NOT WHILE AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinionresulted from Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE

EXAMINER'S NAME (Type)

Werner U. Spitz, M.D.

Deputy CHIEF MEDICAL EXAMINER ☒ASSISTANT MEDICAL EXAMINER ☐ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

4/22/72

24A. BURIAL CREMATION, REMOVAL (Specify)

Burial

24B. DATE

4/26/72

24C. NAME OF CEMETERY or CREMATORY

MT. CALVARY CEM.

24D. LOCATION (City, town, or county) (State)

A.A. COUNTY, Md.

25A. DATE REC'D BY HEALTH DEPT.

APR 25 1972

25B. NAME OF REGISTRAR

Robert E. Jordan, M.D.

25C. FUNERAL DIRECTOR

M. E. Ellickson - 1129 N. CAROLINE ST.

3/12/1907

Tuesday, N.C.
retired

No

Moses Jones

John Johnson

Barry Jones - son of J. J.

MAIL BOX

Donor

4/26/72 Mt. Carmel Cem. A.A. County, N.C.

M. E. Clarkson - Mt. Carmel Cem.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Baltimore City Health Department				REG. NO. 72 03942	
T-460		72 03942		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <u>Taylor, Marie</u>			2. DATE AND HOUR OF DEATH <u>4-22-72</u> <u>7 P.M.</u>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <u>Good Samaritan Hospital</u> <u>Loch Raven Blvd</u> <u>Balt Md.</u>			A. STATE <u>Maryland</u> & COUNTY <u>808</u>		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
5. SEX <u>F</u> 6. RACE <u>B</u>			7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>05-06-07</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			10B. KIND OF BUSINESS OR INDUSTRY —		9. AGE (In years last birthday) <u>64</u>
11. BIRTHPLACE (State or foreign country) <u>Virginia</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>PARKMAN, Wm.</u>			14. MOTHER'S MAIDEN NAME <u>FEGLANS, DE LIA</u>		
15. Was Deceased Ever in U.S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>			16. SOCIAL SECURITY NO. <u>999-99-917</u>		
17. INFORMANT <u>Dorothy Rice</u>			ADDRESS <u>4407 Sprigle Ave.</u>		
18. <u>162-1</u> CAUSE OF DEATH			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>RESPIRATORY ARREST</u>			<u>IMMED.</u>		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last, <u>CARCINOMA LUNG</u>			<u>1 YEAR</u>		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>4-17</u> 19 <u>72</u> to <u>4-22</u> 19 <u>72</u> that (I) (we) last saw the deceased alive on <u>4-22</u> 19 <u>72</u> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>William A. Carter MD</u>				23B. DATE SIGNED <u>4.22.72</u>	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <u>4-28-72</u>		24C. NAME OF CEMETERY or CREMATORY <u>Arbutus Mem. Park</u>	
24D. LOCATION <u>Arbutus, Md.</u>		24E. DATE REC'D BY HEALTH DEPT.		24F. NAME OF REGISTRAR	
24G. DATE REC'D BY HEALTH DEPT.		24H. NAME OF REGISTRAR		24I. FUNERAL DIRECTOR <u>Frank E. Chickson</u>	
24J. ADDRESS		24K. ADDRESS		24L. ADDRESS	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 03943	
W-420 72 03943		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH		3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD	
MAMIE WELLS		4-17-72 8:00 P M.		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION THE JOHNS HOPKINS HOSPITAL 33		A. STATE MARYLAND		B. CITY OR TOWN	
				D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER 2414 E. HOFFMAN ST.		C. CITY OR TOWN BALTIMORE		F. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		G. STREET AND NUMBER 2414 E. HOFFMAN ST.			
5. SEX FEMALE	6. RACE NEGRO	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-15-09	9. AGE (In years last birthday) 63	10. UNDER 1 Yr. Months Days Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
12. FATHER'S NAME JOHNNIE Singleton		13. MOTHER'S MAIDEN NAME ROSE SINGLETON		14. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Rochelle Bell-2439 E. Hoffman St.	
18. CAUSE OF DEATH		DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
<p>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)</p> <p>ANTECEDENT CAUSES</p> <p>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p>		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
		(B) DUE TO, OR AS A CONSEQUENCE OF:			
II		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) 4 17 72 8:00 PM		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this is a true statement) attended the deceased from 4/11/72 to 4/17/72 that (I) (we) last saw the deceased alive on 4/17/72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Terrence Horrigan		23B. DATE SIGNED 4/17/72		23C. PHYSICIAN'S NAME (Type) Terrence Horrigan, M.D.	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE 4-22-72		24C. NAME OF CEMETERY OR CREMATORY Mt. Auburn Cem.	
24D. LOCATION (City, town, or county)		24E. NAME OF REGISTRAR Milton E. Erickson		24F. FUNERAL DIRECTOR Milton E. Erickson	
25A. DATE REC'D BY HEALTH DEPT. APR 25 1972		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	

ST. 24. 9

44-20-0

0820 34-47

2-13-20 33-47

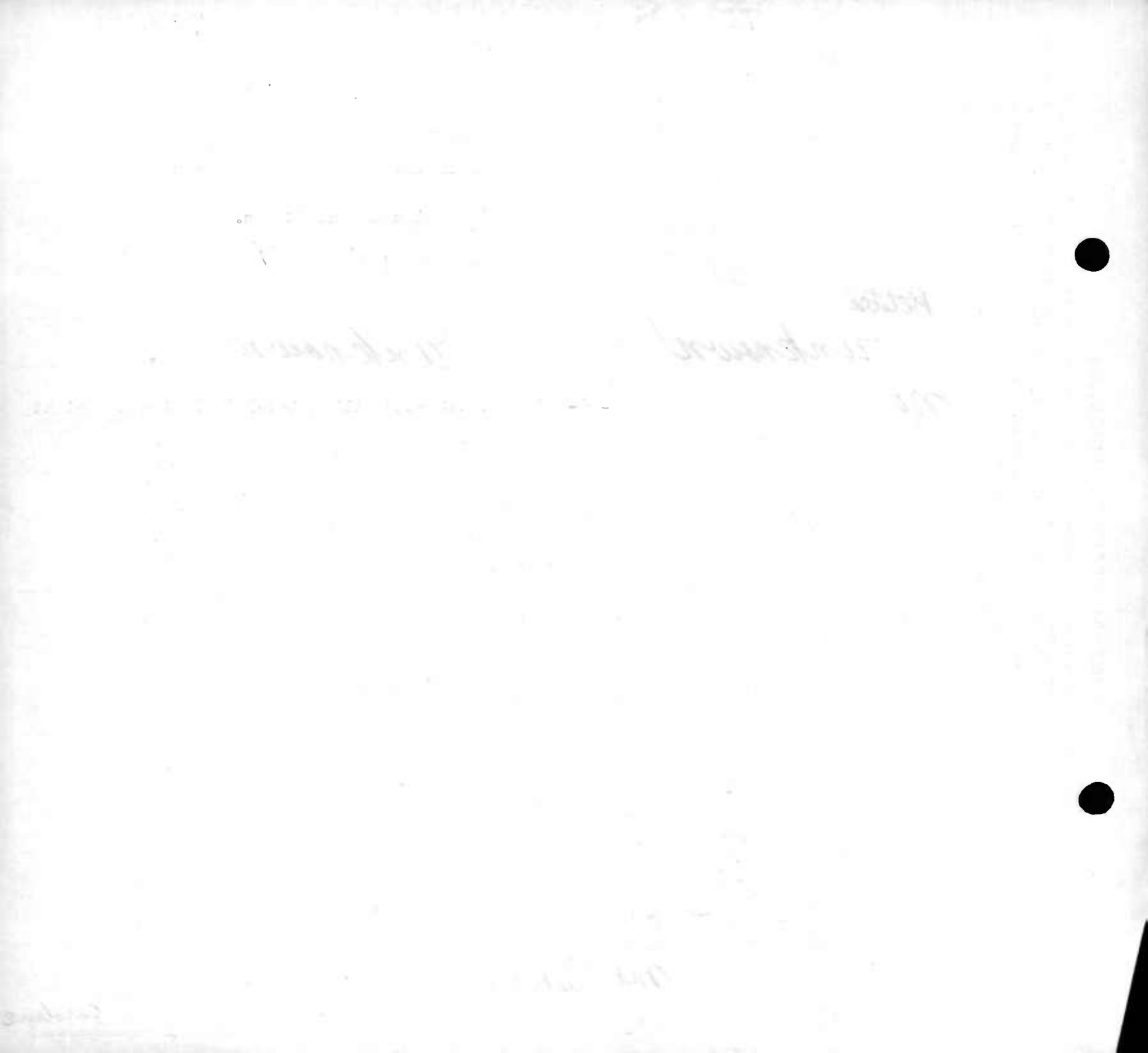
21-20-14

347

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Baltimore City Health Department				REG. NO. <u>72 03944</u>	
C-326 72 03944 CATHCART CERTIFICATE OF DEATH					
1. NAME OF DECEASED (Type or Print) <u>Cathcart, George</u>		2. DATE AND HOUR OF DEATH <u>April 24, 72</u> <u>2 25</u> A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <u>39 Proudrent Hosp</u>		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore</u> C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>4009 Liberty Height Ave.</u>			
5. SEX <u>M</u>	6. RACE <u>N</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-15-39</u>	9. AGE (In years lost birthday) <u>33</u>	10. If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>West Indies</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. Was Deceased Ever In U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>109-07-1022</u>		17. INFORMANT <u>Antoinette Hill (Niece)</u> ADDRESS <u>4009 Liberty Height</u>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Anticoagulant cardiovascular disease</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. <u>Chronic renal insufficiency & uremia & GI bleeding</u>		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Chronic renal insufficiency & uremia & GI bleeding</u>		(B) DUE TO, OR AS A CONSEQUENCE OF: <u>Dehydration</u>	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>Cellulitis Rt. thigh @ 2° infection</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>April 17</u> 19 <u>72</u> to <u>April 24</u> 19 <u>72</u> that (I) (we) last saw the deceased alive on <u>April 24</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>V. Chitraplee</u>		23B. DATE SIGNED <u>April 24, 72</u>		23C. PHYSICIAN'S NAME (Type) <u>V. Chitraplee</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>4-26-72</u>		24C. NAME of CEMETERY or CREMATORY <u>Mt. Auburn Cem.</u>	
24D. LOCATION (City, town, or county) (State) <u>Westport Md.</u>		25A. DATE REC'D BY HEALTH DEPT. <u>APR 25 1972</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor R.D.</u>	
25C. FUNERAL DIRECTOR <u>Milton L. Collickson</u>		25D. ADDRESS <u>1129 N. Caroline</u>			



72 03945

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

72 03945

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

CHESTER HANNA

2. DATE
OF
DEATHKnown ☐ Estimated ☐

Month

Day

Year

Hour

M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL
OR INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)3. DATE
PRONOUNCED DEAD

Month

Day

Year

Hour

M.

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

00 2571 W. Fayette St.

Md.

2002

6. SEX

male

7. RACE

negro

8. MARRIED ☒ NEVER MARRIED ☐WIDOWED ☐DIVORCED ☐

C. CITY OR TOWN

Balto.

D. INSIDE CITY LIMITS?

YES ☒NO ☐

9. DATE OF BIRTH

12-10-1916

10. AGE (In years
last birthday)

55

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

E. STREET AND NUMBER

2571 W. Fayette St.

11. BIRTHPLACE (State or foreign country)

Florence Co, S. C.

12. CITIZEN OF
WHAT COUNTRY?
U. S. A.

13. FATHER'S NAME

Bonn Hanna

14A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

14B. KIND OF BUSINESS OR INDUSTRY

Construction

15. MOTHER'S MAIDEN NAME

Rebecca Hanna

16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

17. SOCIAL
SECURITY NO.

251-66-0283

18. INFORMANT

Mrs. Costeal McFadden

ADDRESS

2547 W. Fayette St.

19. E880X I

CAUSE OF DEATH

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

Multiple Injuries

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART 1 (A).

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

yes

22A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg., etc.)22C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?

home

2571 W. FAYETTE ST.

22D. TIME (Month) (Day) (Year) (Hour)
OF INJURY (APPROX.)22E. INJURY OCCURRED
WHILE AT WORK ☐ NOT WHILE
AT WORK ☒

22F. HOW DID INJURY OCCUR?

4-23-72 ? FELL DOWN STEPS.

23.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Russell S. Fisher, M.D.

CHIEF MEDICAL EXAMINER ☒
ASSISTANT MEDICAL EXAMINER ☐
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

4-24-72

24A. BURIAL CREMATION,
REMOVAL (Specify)
Burial

24B. DATE

4-28-72

24C. NAME of CEMETERY or CREMATORY

McKenzie Cemetery

24D. LOCATION (City, town, or county) (State)

Lake City, South Carolina

25A. DATE REC'D BY HEALTH DEPT.

APR 25 1972

25B. NAME OF REGISTRAR

Robert E. Fisher, M.D.

25C. FUNERAL DIRECTOR

ADDRESS

Morton & Dyett Funeral Homes, Inc.

1701 Laurens St. Balto, Md.

10-10-1916

10-10-1916
Florence Co., S. C.
Construction
Rebecca Hill
The State of Georgia
No. 10-10-1916

Handwritten signature
10-10-1916
L. K. Rice, Secy. of State
The State of Georgia
10-10-1916

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

72 03946

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

LESLIE BOWLER

2. DATE
OF
DEATHKnown ☐ Estimated ☐

Month

Day

Year

Hour

M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL
OR INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

00 3712 Woodridge Rd.

3. DATE
PRONOUNCED DEAD

Month

Day

Year

Hour

M.

4

23

1972

11:07a

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Washington, D.C.

V48

6. SEX

male

7. RACE

negro

B. MARRIED ☐ NEVER MARRIED ☒WIDOWED ☐ DIVORCED ☐

C. CITY OR TOWN

D. INSIDE CITY LIMITS?

YES ☐NO ☐

9. DATE OF BIRTH

11-4-1904

10. AGE (In years
last birthday)

67

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

E. STREET AND NUMBER

1644 Rosedale St., N.E.

11. BIRTHPLACE (State or foreign country)

Essex County, Virginia

12. CITIZEN OF
WHAT COUNTRY?
U. S. A.

13. FATHER'S NAME

Henry Bowler

14A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

Mattie Gresham

16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)17. SOCIAL
SECURITY NO.
212-10-3011

18. INFORMANT

ADDRESS

Mrs. Garnetta Watkins-3712 Woodridge Road

19. 412.4 I

CAUSE OF DEATH

Arteriosclerotic cardiovascular disease

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART I (A).

MEDICAL CERTIFICATION

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

no

22A. EXTERNAL CAUSE WAS
UNDERLYING ☐ OR CONTRIB-
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg., etc.)22C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?22D. TIME (Month) (Day) (Year) (Hour)
OF INJURY (APPROX.)

22E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Russell S. Fisher, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☒ASSISTANT MEDICAL EXAMINER ☐ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

4-24-72

24A. BURIAL CREMATION,
REMOVAL (Specify)
Burial

24B. DATE

4-27-72

24C. NAME OF CEMETERY or CREMATORY

Mt. Auburn Cemetery

24D. LOCATION (City, town, or county) (State)

Baltimore, Maryland

25A. DATE REC'D BY HEALTH DEPT.

25B. NAME OF REGISTRAR

25C. FUNERAL DIRECTOR

ADDRESS

Street

APR 25 1972

Morton & Dyett Funeral Home-1701 Laurens

1970 S

11-1-1970

Henry Taylor, Jr., A. A. Taylor, Virginia

Radio Group

11-1-1970 Mr. Robert W. Taylor - 11-1-1970

Radio Group to Mr. Taylor - 11-1-1970

Handwritten signature

11-7-70 Mr. Taylor, Jr., A. A. Taylor, Virginia

Radio Group to Mr. Taylor - 11-7-70

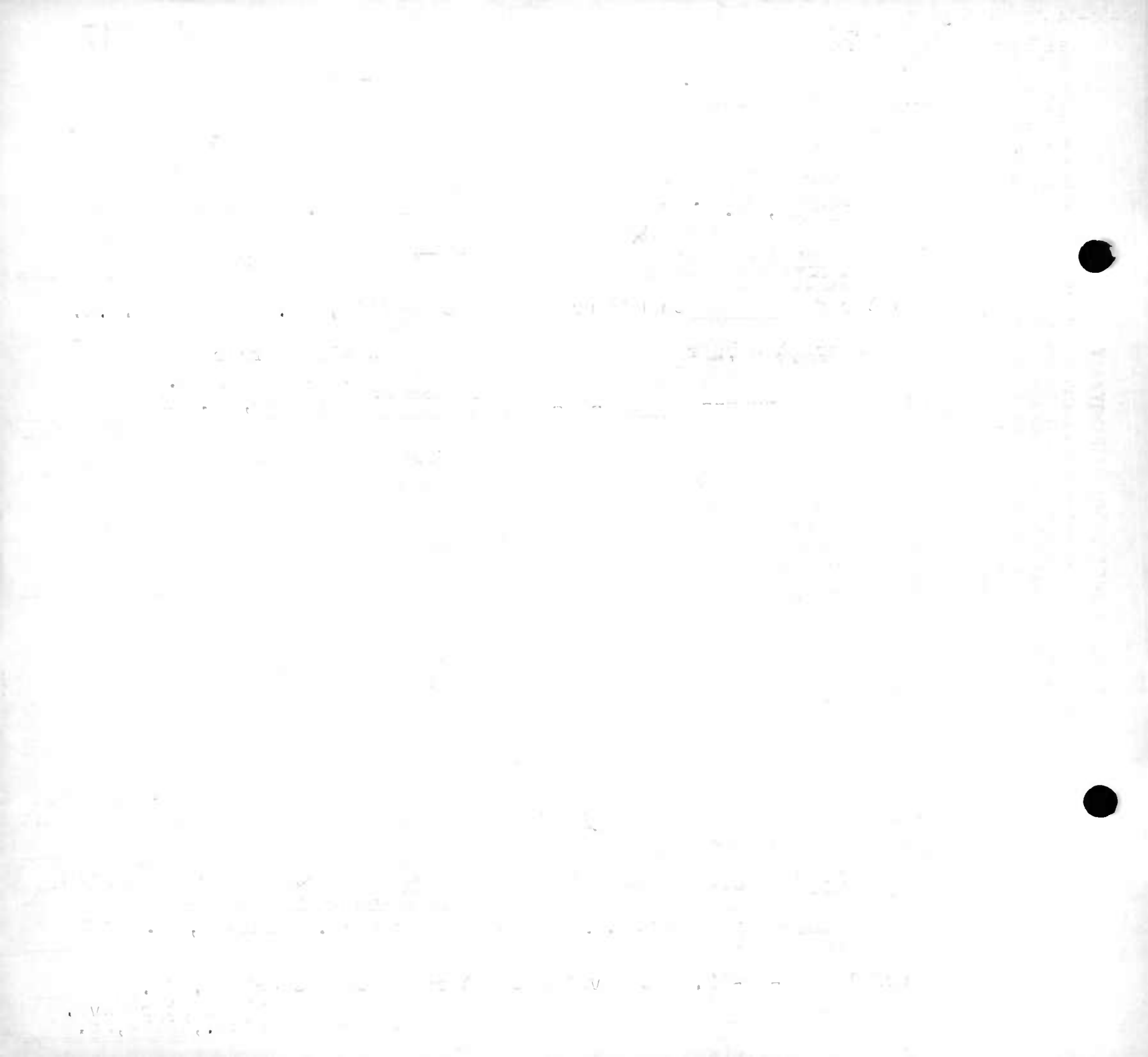
CERTIFICATE OF DEATH

REG. NO. 72 03947

BIRTH NO. <u>H 65672 03947</u>		1. NAME OF DECEASED (Type or Print) <u>Chesley M. Horner</u>		2. DATE AND HOUR OF DEATH <u>4-23-72</u> <u>6:45 A</u> M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>31 Baltimore City Hospitals</u> <u>4940 Eastern Ave.</u> <u>Baltimore, Md. 21224</u>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>2605</u>		C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <u>Male</u>		6. RACE <u>Caucasion</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <u>9-15-07</u>		9. AGE (in years lost birthday) <u>64</u>		If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Chauffeur</u>		11. BIRTHPLACE (State or foreign country) <u>Capeville, Va.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Forrest Horner</u>		14. MOTHER'S MAIDEN NAME <u>Amelia Parker</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>224-16-2154</u>		17. INFORMANT <u>BCH Records:</u> ADDRESS <u>4940 Eastern Ave. Baltimore, Md. 21224</u>	
18. <u>412.3 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <u>Cardiogenic Shock</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>ASHD</u>		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>ASHD</u> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>3 hours</u> <u>2 years</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPRDX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>4/21</u> 19 <u>72</u> to <u>4/23</u> 19 <u>72</u> that (I) (we) last saw the deceased alive on <u>4/23</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Robert Lloyd Ruxin M.D.</u>		23B. DATE SIGNED <u>4/23/72</u>		23C. PHYSICIAN'S NAME (Type) <u>Robert Lloyd Ruxin M.D.</u>	
23D. ADDRESS <u>Baltimore City Hospitals</u>		23E. FUNERAL DIRECTOR <u>Charles S. Zeller</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>4-26-72</u>		24C. NAME of CEMETERY or CREMATORY <u>Capeville Cemetery</u>	
24D. LOCATION (City, town, or county) (State) <u>Cape Charles, Va.</u>		25A. DATE REC'D BY HEALTH DEPT. <u>APR 25 1972</u>			
25B. NAME OF REGISTRAR <u>Robert E. Taylor, M.D.</u>		25C. ADDRESS <u>6224 Eastern Ave. Balto., 21224, Md.</u>			

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.



D-400

72 03948

BALTIMORE CITY HEALTH DEPARTMENT

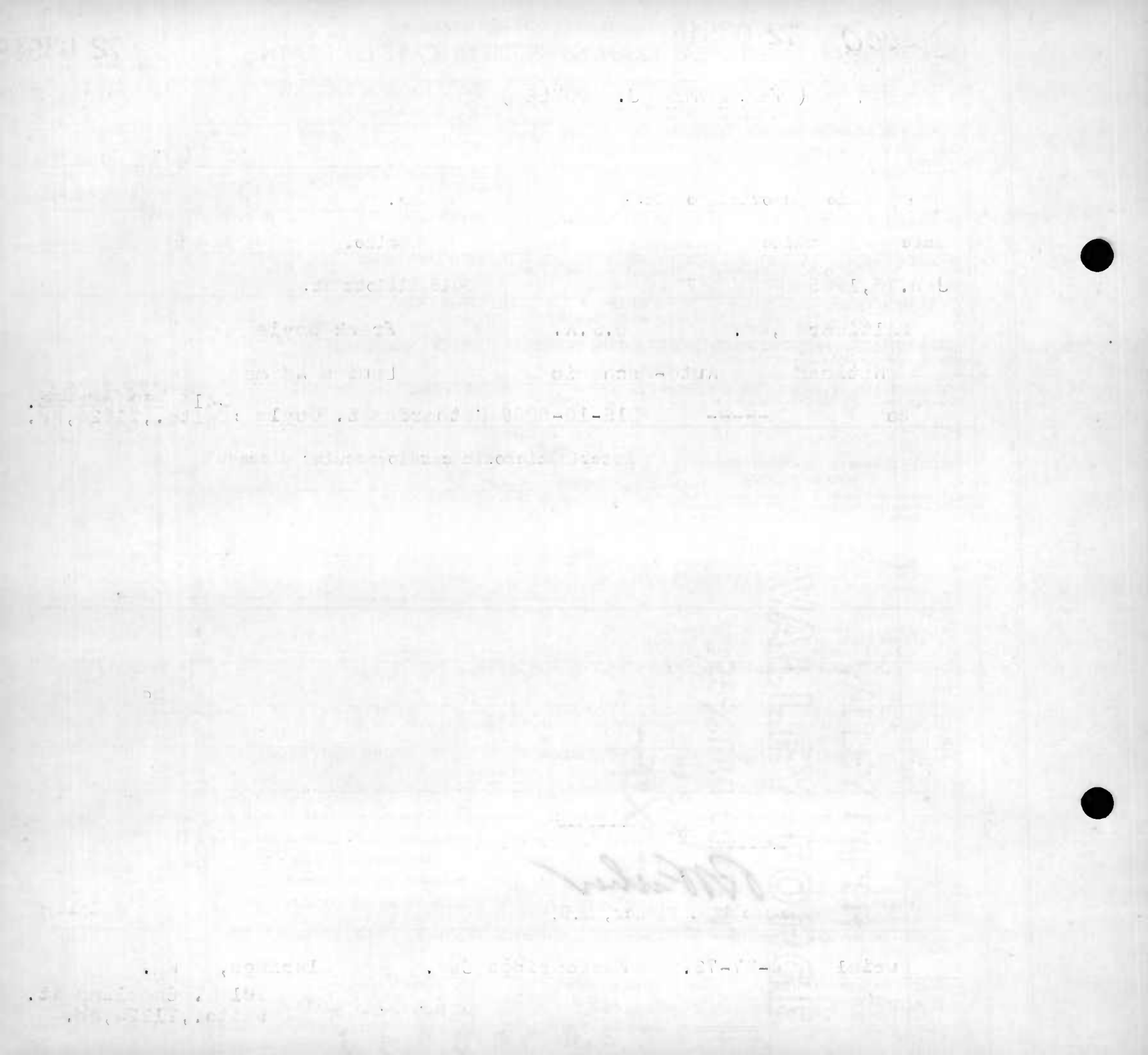
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

72 03948

BIRTH NO.

1. NAME OF DECEASED (Type or Print) FERDINAND J. DOYLE FERDINAND DOYLE		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> Month Day Year	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 44 Union Memorial Hospital		3. DATE PRONOUNCED DEAD Month Day Year 4 23 1972 Hour 7:08 p.m.	
6. SEX male		7. RACE white	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Balto.	
9. DATE OF BIRTH Jan. 26, 1905		10. AGE (In years last birthday) 67	
11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF U.S.A.	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		14B. KIND OF BUSINESS OR INDUSTRY Auto-Mechanic	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		17. SOCIAL SECURITY NO. 215-10-5089	
18. INFORMANT Katherine E. Doyle		ADDRESS 3416 Elliott St. Balto., 21224, Md.	
19. CAUSE OF DEATH Arteriosclerotic cardiovascular disease		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(B) DUE TO, OR AS A CONSEQUENCE OF:	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		(C) DUE TO, OR AS A CONSEQUENCE OF:	
20A. DATE OF OPERATION 0		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?		22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE Russell S. Fisher, M.D. EXAMINER'S NAME (Type) DATE SIGNED 4-24-72			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4-27-72.	
24C. NAME OF CEMETERY or CREMATORY Meadowridge Cem.		24D. LOCATION (City, town, or county) (State) Elkridge, Md.	
25A. DATE REC'D BY HEALTH DEPT. APR 25 1972		25B. NAME OF REGISTRAR Robert E. Fisher, M.D.	
25C. FUNERAL DIRECTOR Charles S. Seiler		ADDRESS 901 S. Conkling St. Balto., 21224, Md.	



J-620

72 03949

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

72 03949

REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) (WANDA E. JARZY) WANDA JARZY		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 31 Baltimore City Hospital		3. DATE PRONOUNCED DEAD Month Day Year Hour 4 24 1972 12:10 a.	
5. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE Md. B. COUNTY 2605		C. CITY OR TOWN Balto. D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
6. SEX female	7. RACE white	B. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH Nov. 20, 1906	10. AGE (In years lost birthday) 65	E. STREET AND NUMBER 306 Folcroft St. # 21224.	
11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY?	
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unemployed		15. MOTHER'S MAIDEN NAME Hattie Spochacz	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		17. SOCIAL SECURITY NO.	
18. INFORMANT Genevieve Rieselmann		ADDRESS Same (Sister)	
19. CAUSE OF DEATH 412.4 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH Arteriosclerotic cardiovascular disease (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). 20A. DATE OF OPERATION 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED 21. AUTOPSY? (Yes or No) no 22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 22D. TIME OF INJURY (Month) (Day) (Year) (Hour) 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> 22F. HOW DID INJURY OCCUR? 23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Russell S. Fisher, M.D. EXAMINER'S NAME (Type) CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 4-24-72			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4-26-72.	
24C. NAME OF CEMETERY or CREMATORY Sacred Heart Cem.		24D. LOCATION (City, town, or county) (State) 7401 German Hill Rd., Ba. Co. Md.	
25A. DATE REC'D BY HEALTH DEPT. APR 25 1972		25B. NAME OF REGISTRAR Robert E. Fisher, M.D.	
25C. FUNERAL DIRECTOR Charles S. Seiler		ADDRESS 6224 Eastern Ave. Balto., 21224, Md.	

(Yankee ...)

...
...
...
...

...
...

...
...

WALKER

Walker

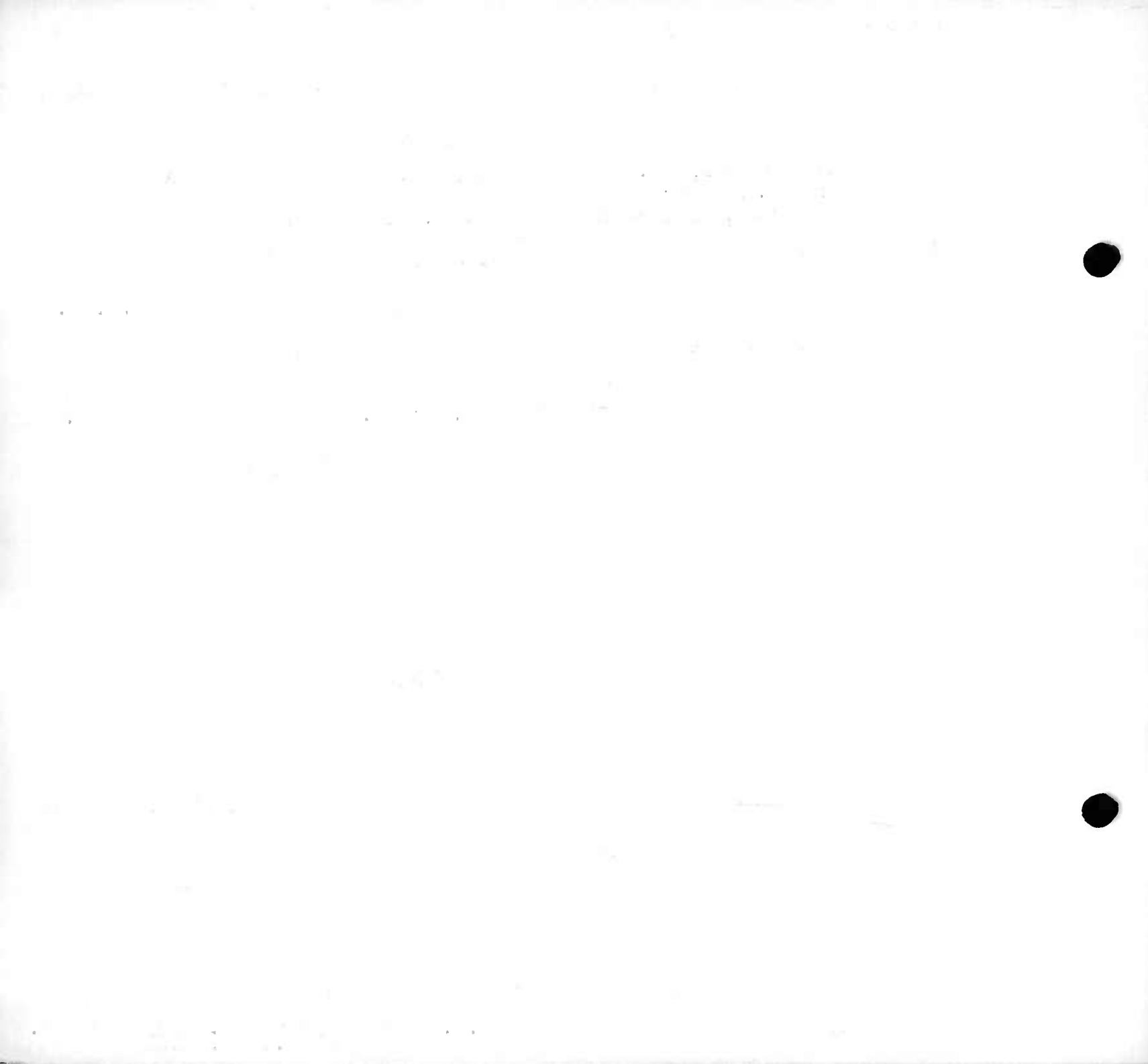
...

...
...
...
...

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. 72 03950	
BIRTH NO. L-321		72 03950			
1. NAME OF DECEASED (Type or Print) <div style="text-align: center;">Alvin LATCHFORD</div>			2. DATE AND HOUR OF DEATH April 24, 1972 4:15 A.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <div style="text-align: center;">Midtown Home, Inc. 808 St. Paul Street Baltimore, Maryland 21202</div>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE 1102 Maryland C. CITY OR TOWN 1102 Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 212 W. Monument Street		
5. SEX M	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5/10/77	9. AGE (In years last birthday) 94	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ?		10B. KIND OF BUSINESS OR INDUSTRY ?		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Joseph Latchford			14. MOTHER'S MAIDEN NAME Mary Fitzsimmons		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 218-10-6867		17. INFORMANT Mrs. Jane K. Insley 226 Dukirk Rd.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Cardio Respiratory Failure Antepartum CVD (B) Seminal DUE TO, OR AS A CONSEQUENCE OF: Gen + Core Brain Antepartum (C) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (initially medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from March 13 1961 to April 24, 1972 that (I) (we) last saw the deceased alive on Apr 24 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did not) view the body after death.					
23A. SIGNATURE <div style="text-align: center;">William Appleford</div>				23B. DATE SIGNED 4/24/72	
23C. PHYSICIAN'S NAME (Type) William Appleford				23D. ADDRESS 6615 New Jerusalem Rd	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4/26/72		24C. NAME of CEMETERY or CREMATORY New Cathedral	
24D. LOCATION Baltimore		24E. LOCATION (City, town, or county) (State) Maryland			
25A. DATE REC'D BY HEALTH DEPT. APR 25 1972		25B. NAME OF REGISTRAR Robert E. Jaber, M.D.		25C. FUNERAL DIRECTOR H.W. Jenkins & Sons Co. 4905 York Rd. Balto., Md. 21212	



FUNERAL DIRECTOR: IMPORTANT

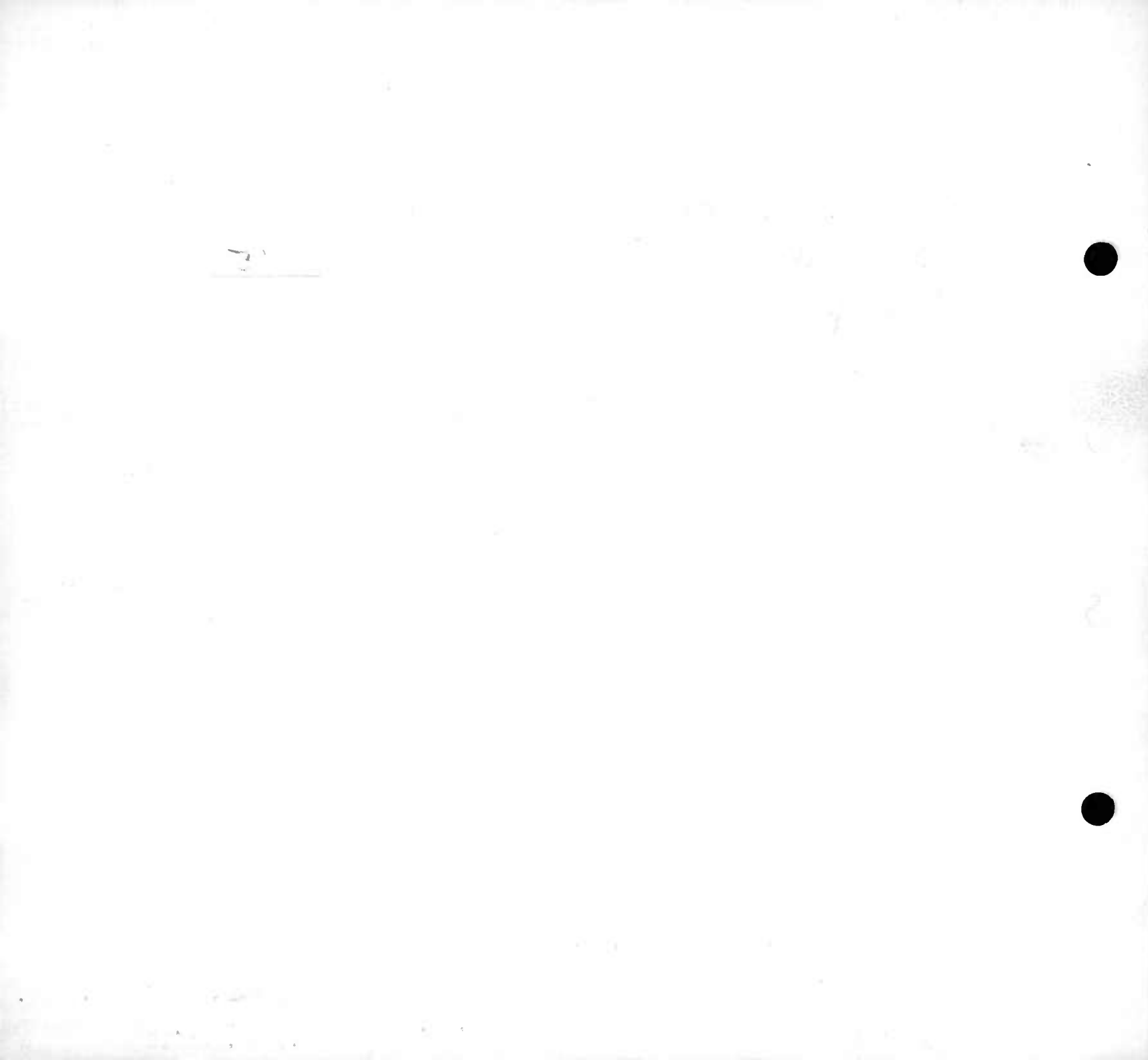
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Baltimore City Health Department				REG. NO. _____	
C-160 72 03951		72 03951 CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
William Harvey Cooper		4-22-72		2:30 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 00 323 Tuscany Road		A. STATE		B. COUNTY	
		Md.		1201	
		C. CITY OR TOWN		D. INSIDE CITY LIMITS?	
		Balto.		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER			
		323 Tuscany Rd.			
5. SEX	6. RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months Days
M	W	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	1-6-1917	55	If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Financial Director		School of J.H.U. Hygiene		Md.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
William Harvey Cooper		Elsie Poole		USA	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT	
Yes WW 11		410-10-9994		Elizabeth O. Cooper	
				ADDRESS	
				Above	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		- 1 hr.	
ANTECEDENT CAUSES		(B) DUE TO, OR AS A CONSEQUENCE OF:			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) DUE TO, OR AS A CONSEQUENCE OF:			
II		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
				No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
(Month) (Day) (Year) (Hour)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from April 22 1972 to April 22 1972, that (I) (we) last saw the deceased alive on _____ 19____ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE		23B. DATE SIGNED			
Bernard J. Cohen, M.D.		4-24-72			
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
Bernard J. Cohen Md		Marylander Apts., Balto., Md.			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		4-27-72		Gettysburg National	
				Gettysburg Pa.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
APR 25 1972		H.W. Jenkins & Sons Co., Balto., Md.		ADDRESS	

[Faint, illegible text, likely bleed-through from the reverse side of the page. The text is mirrored and difficult to decipher.]

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
72 03952					REG. NO. 72 03952				
BIRTH NO. <u>P-456</u>					1. NAME OF DECEASED (Type or Print) <u>Helen E. Palmer</u>				
2. DATE AND HOUR OF DEATH <u>4/24/72 - 2:45 pm</u>					M. <u>2748</u>				
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>Edgewood Nursing Home</u> <u>6000 Belkona Ave - Balto. Md.</u>					4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Baltimore</u> B. COUNTY <u>Harford</u> C. CITY OR TOWN <u>Balto.</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>md</u>				
5. SEX <u>F</u>	6. RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7/18/1906</u>	9. AGE (In years last birthday) <u>65</u>	If Under 1 Yr. Months: Days: Hours: Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		
11. BIRTHPLACE (State or foreign country) <u>W. Va.</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			13. FATHER'S NAME <u>Harry M. Hopkins</u>			
14. MOTHER'S MAIDEN NAME <u>HELEN ZIEGLER</u>			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>			16. SOCIAL SECURITY NO. <u>216-20-8545A</u>			
17. INFORMANT <u>ROBERT E. PALMER (SAME)</u>			ADDRESS <u>4000 W. Northern Parkway</u>			18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Myocardial Infarction</u>			
19. CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Myocardial Infarction</u> (B) <u>Heart</u> (C) <u>Hypertensive Cardiovascular Disease</u>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>3 months</u> <u>10 years</u>			II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>Heart Disease</u>			
19A. DATE OF OPERATION <u>4/2/72</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Exploratory</u>		20A. AUTOPSY? (Yes or No) <u>No</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (1) (this hospital) attended the deceased from <u>2/19/72</u> 19 <u>72</u> to <u>4/24</u> 19 <u>72</u> that (1) (we) last saw the deceased alive on <u>4/24</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <u>Israel S. Zinberg</u>				23B. DATE SIGNED <u>4/24/72</u>		23C. PHYSICIAN'S NAME (Type) <u>Israel S. Zinberg, M. D.</u>			
23D. ADDRESS <u>4000 W. Northern Parkway</u>		24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>							
24B. DATE <u>4/26/72</u>		24C. NAME OF CEMETERY OR CREMATORY <u>All Saints</u>		24D. LOCATION (City, town, or county) (State) <u>Oakley St. Mary's Co., Md.</u>		25A. DATE REC'D BY HEALTH DEPT. <u>APR 25 1972</u>			
25B. NAME OF REGISTRAR <u>Robert E. Palmer, M.D.</u>		25C. FUNERAL DIRECTOR <u>H. W. Jenkins & Sons Co.</u>		ADDRESS <u>4905 York Rd Balto., Md. 21212</u>					



72 03953

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

72 03953

BIRTH NO.

1. NAME OF DECEASED (Type or Print) JOHN/LEAHY		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 614 N. Howard Street		3. DATE PRONOUNCED DEAD Month Day Year Hour April 21, 1972 7:36 A.M.	
6. SEX Male		7. RACE White	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore	
9. DATE OF BIRTH 2/12/1903		10. AGE (In years lost birthday) 69 If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) Wilmington, Delaware		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		14B. KIND OF BUSINESS OR INDUSTRY Leatherworker	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		17. SOCIAL SECURITY NO.	
15. MOTHER'S MAIDEN NAME Maggie Kelley		18. INFORMANT Wilmington, Delaware Mrs. Joseph Hall, 2709 Thompson Pl.	
19. 412.4 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease		CAUSE OF DEATH Arteriosclerotic cardiovascular disease	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		(B) DUE TO, OR AS A CONSEQUENCE OF:	
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?		22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE: Ronald N. Kornblum, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type): Ronald N. Kornblum, M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED: 4/21/72			
24A. BURIAL CREMATION, REMOVAL (Specify) Removal-Burial		24B. DATE 4/28/72	
24C. NAME OF CEMETERY or CREMATORY CATHEDRAL		24D. LOCATION (City, town, or county) (State) WILMINGTON, DELAWARE	
25A. DATE REC'D BY HEALTH DEPT. APR 25 1972		25B. NAME OF REGISTRAR Robert E. Jenkins, M.D.	
25C. FUNERAL DIRECTOR H.W. Jenkins & Sons Co.		ADDRESS 4905 York Rd. Balto., Md. 21212	

OFFICE OF THE SECRETARY OF DEFENSE

MEMORANDUM FOR THE SECRETARY OF DEFENSE

SUBJECT: [Illegible]

DATE: [Illegible]

FROM: [Illegible]

TO: [Illegible]

1. [Illegible]

2. [Illegible]

3. [Illegible]

4. [Illegible]

5. [Illegible]

6. [Illegible]

7. [Illegible]

8. [Illegible]

9. [Illegible]

10. [Illegible]

11. [Illegible]

12. [Illegible]

13. [Illegible]

14. [Illegible]

15. [Illegible]

16. [Illegible]

17. [Illegible]

18. [Illegible]

19. [Illegible]

20. [Illegible]

21. [Illegible]

22. [Illegible]

23. [Illegible]

24. [Illegible]

25. [Illegible]

[Handwritten signature]

BALTIMORE CITY HEALTH DEPARTMENT
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

72 03954

BIRTH NO. _____ REG. NO. _____

1. NAME OF DECEASED (Type or Print) Eugene ARNOLD HORNE		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) LUTHERAN HOSPITAL (DOA)		3. DATE PRONOUNCED DEAD Month Day Year Hour April 19, 1972 12:20 A.M.	
6. SEX Male		7. RACE Negro	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> Sep DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY 1506	
9. DATE OF BIRTH Sept. 23, 1947		10. AGE (In years lost birthday) 24 If Under 1 Yr. II Under 24 Hrs. Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		13. FATHER'S NAME Irvin Horne	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		14B. KIND OF BUSINESS OR INDUSTRY	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		17. SOCIAL SECURITY NO. 217-46-0040	
18. INFORMANT Mr. & Mrs. Irvin Horne		ADDRESS 2005 Braddish Avenue	
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) E955X1 Gunshot wound of head (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) yes			
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Alley	
22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) Rear 3100 Normount		22D. TIME OF INJURY (Approx.) 4-18-72 11:20 P.m.	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? Self-inflicted	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE: <i>Ronald N. Kornblum</i> M.D. EXAMINER'S NAME (Type): Ronald N. Kornblum, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED: 4/19/72			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4-22-72	
24C. NAME of CEMETERY or CREMATORY Arbutus MEm. Park		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. APR 25 1972		25B. NAME OF REGISTRAR Robert E. Fahey, M.D.	
25C. FUNERAL DIRECTOR Arlington S. Phillips		ADDRESS 1727 N. Monroe Street	

VS 151-REV. 1/1/68

1000

1000



T-514

72 03955

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 72 03955

BIRTH NO.

1. NAME OF DECEASED (Type or Print) George F. Temple		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input checked="" type="checkbox"/> 4 22 72 1150 A.M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 44 Union Memorial Hosp		3. DATE PRONOUNCED DEAD Month Day Year Hour 4 22 72 1150 A.M.	
5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MD B. COUNTY 2747		C. CITY OR TOWN Balto	
6. SEX M	7. RACE Cauc	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
9. DATE OF BIRTH Oct. 30, 1910.	10. AGE (In years last birthday) 61	E. STREET AND NUMBER 6406 Laurelton Ave	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Seafood Cleaner		15. MOTHER'S MAIDEN NAME Emma Yeager	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		17. SOCIAL SECURITY NO. 212-03-7219	
18. INFORMANT Mrs. Dora Temple		ADDRESS (Same)	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Intermittent Cardiac Disease DUE TO, OR AS A CONSEQUENCE OF: DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. Cardiovascular Disease DUE TO, OR AS A CONSEQUENCE OF: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?		21. AUTOPSY? (Yes or No) NO	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Werner U. Spitz M.D. CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> EXAMINER'S NAME (Type) WERNER U. SPITZ, M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 4.23.72			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4/26/72.	
24C. NAME OF CEMETERY or CREMATORY Baltimore Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT. APR 25 1972		25B. NAME OF REGISTRAR Robert E. J. [illegible]	
25C. FUNERAL DIRECTOR Leonard J. Ruck, Inc. Balto. Md. 21214		ADDRESS	

19720003950

Baltimore, Md.

Baltimore Camera Co.

11/26/77.

Prints

X X

Print

WALTER

Walter
Walter
Walter

325-1212 Mrs. Dora Temple (Sam)

Sam Temple

Self-employed

Sanford C. Temple

USA

George F. Temple

Oct. 30, 1970.

Mr. Temple

Walter
Walter
Walter

George F. Temple

11/26/77

FUNERAL DIRECTOR: IMPORTANT

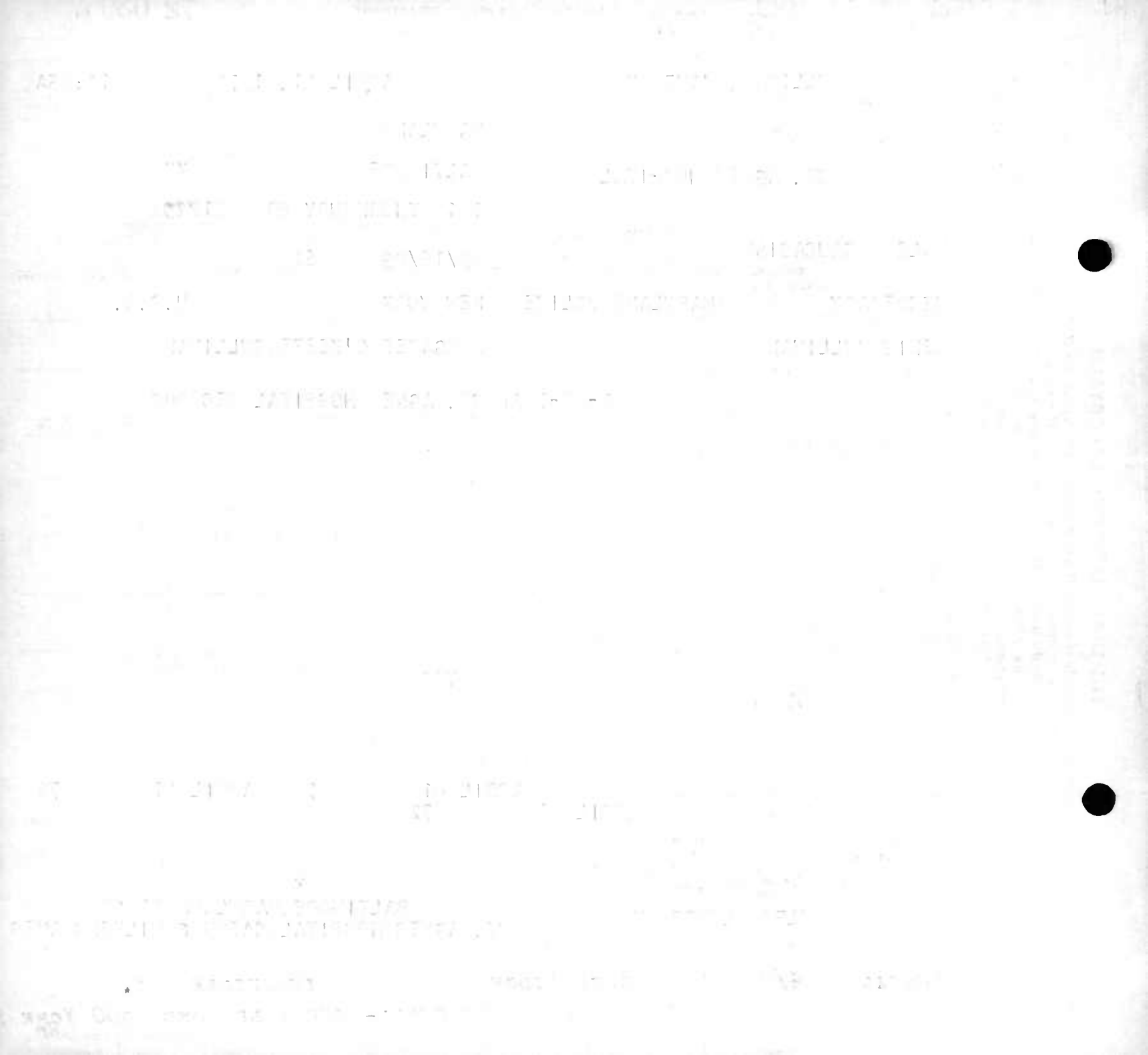
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>72 03956</u>	
7-656 72 03956		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <u>HARRIET FREANER</u>		2. DATE AND HOUR OF DEATH <u>4/21/72</u> <u>9:45</u> P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <u>418 BENINGHAUS RD.</u> <u>BALTO. 21212.</u>		A. STATE <u>MD.</u> B. COUNTY <u>2712</u> C. CITY OR TOWN <u>BALTO.</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>AS ABOVE.</u>			
5. SEX <u>F.</u>	6. RACE <u>W.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8/20/1910</u>	9. AGE (In years last birthday) <u>61</u>	10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>PRINTING</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>SUPERVISOR</u>		11. BIRTHPLACE (State or foreign country) <u>BALTO. M.D.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		13. FATHER'S NAME <u>UNKNOWN Berryman</u>			
14. MOTHER'S MAIDEN NAME <u>UNKNOWN Harriet Cony</u>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) <u>—</u> If yes, give war or dates of service <u>—</u>			
16. SOCIAL SECURITY NO. <u>214-01-9037</u>		17. INFORMANT <u>George G. Freaner</u> ADDRESS <u>HUSBAND 418 Benninghaus Rd</u>			
18. <u>157.9</u> I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>LIVER FAILURE.</u> (B) <u>CARCINOMA PANCREAS.</u> DUE TO, OR AS A CONSEQUENCE OF: (C) <u>NONE.</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>NONE.</u>					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>OCTOBER 1971</u> to <u>PRESENT</u> 19 <u>72</u> that (I) (we) last saw the deceased alive on <u>4/18/1972</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>E. P. Chilimindris</u>		23B. DATE SIGNED <u>4/21/72</u>		23C. PHYSICIAN'S NAME (Type) <u>E. P. CHILIMINDRIS M.D.</u>	
23D. ADDRESS <u>3201 N. CHARLES ST. 21218</u>		24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>			
24B. DATE <u>4/24/72</u>		24C. NAME of CEMETERY or CREMATORY <u>Druid Ridge</u>		24D. LOCATION (City, town, or county) (State) <u>Pikesville Md.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>APR 25 1972</u>		25B. NAME OF REGISTRAR <u>Blue E. Freaner, M.D.</u>		25C. FUNERAL DIRECTOR ADDRESS <u>Mitchell-Wiedefeld Home 6500 York Rd.</u>	

FUNERAL DIRECTOR: IMPORTANT

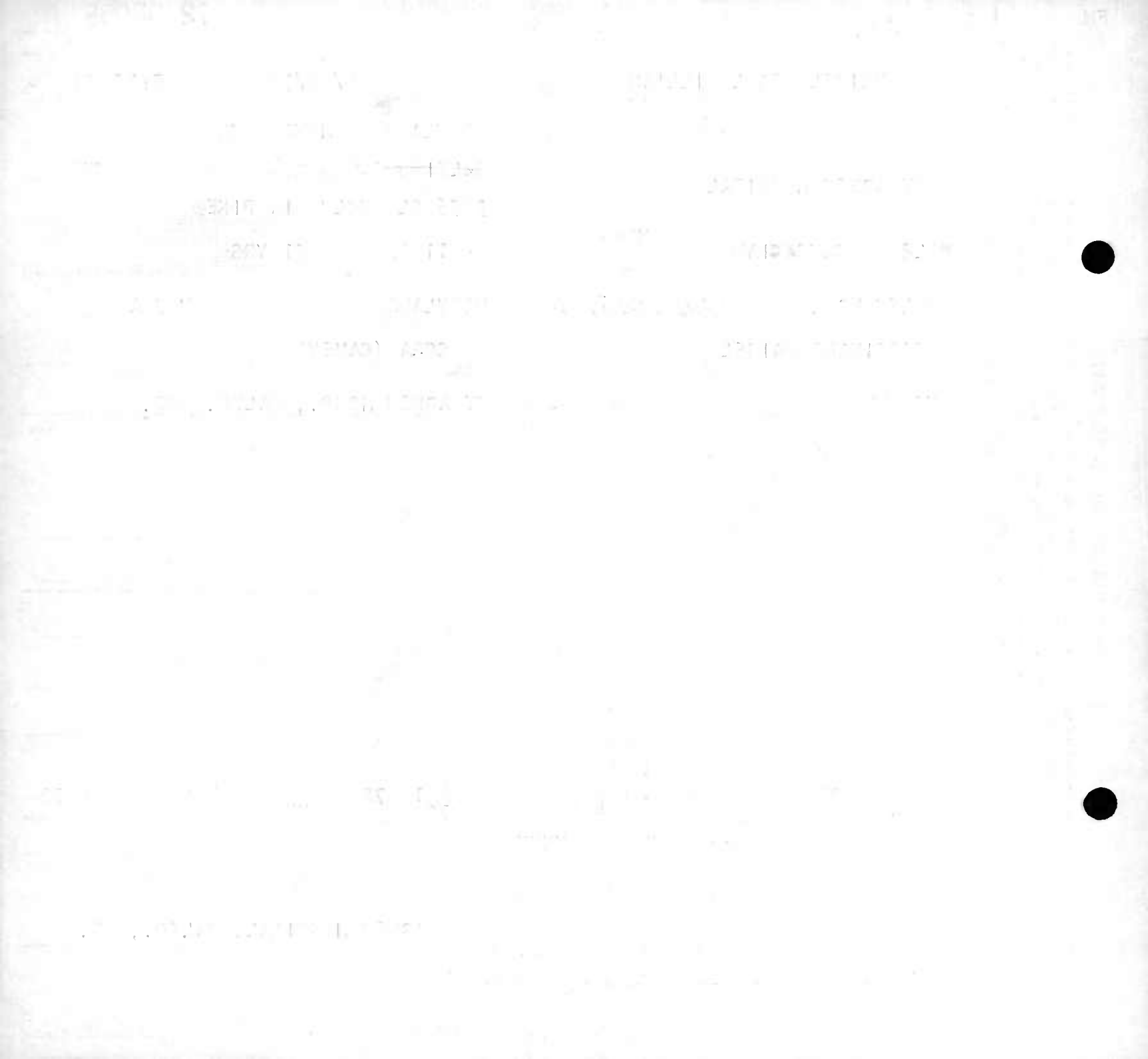
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPT.				REG. NO. _____	
<div style="display: flex; justify-content: space-between;"> S-415 72 03957 CERTIFICATE OF DEATH </div>					
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
SULLIVAN, JAMES V		APRIL 21, 1972		11:45A M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, If institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION 40 ST. AGNES HOSPITAL		A. STATE MARYLAND B. COUNTY 2755			
		C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER 1812 THORNBURY RD 21229			
5. SEX MALE	6. RACE CAUCASIAN	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 09/16/09	9. AGE (In years lost birthday) 62	10. Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SECRETARY		10B. KIND OF BUSINESS OR INDUSTRY MARYLAND POLICE		11. BIRTHPLACE (State or foreign country) NEW YORK	
12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME DENIS SULLIVAN		14. MOTHER'S MAIDEN NAME MARGARET O'KEEFE) SULLIVAN			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 087-09-7830		17. INFORMANT ST. AGNES HOSPITAL RECORDS	
18. 198-131 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Metastatic carcinoma to brain</i> (B) <i>Acute Myocardial Infarction</i> DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 days	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY (Yes or No) YES	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) 1 Month 1 Day 1 Year 1 Hour		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from APRIL 01 19 72 to APRIL 21 19 72 that (I) (we) last saw the deceased alive on APRIL 21 19 72 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Adolfo Alonso</i>		23B. DATE SIGNED			
23C. PHYSICIAN'S NAME (Type) ADOLFO ALONSO MD		23D. ADDRESS BALTIMORE, MARYLAND 21229 ST. AGNES HOSPITAL; CATON & WILKENS AVES			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE 4/24/72		24C. NAME OF CEMETERY or CREMATORY DRAUID RIDGE	
24D. LOCATION (City, town, or county) (State) PIKESVILLE MD.					
25A. DATE REC'D BY HEALTH DEPT. APR 25 1972		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR MITCHELL-WIEDEFELD HOME 6500 York Rd	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <u>M-240</u> <u>72 03958</u>				BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH <u>7</u>		REG. NO. <u>72 03958</u>	
1. NAME OF DECEASED (Type or Print) <u>MAISEL, EARL WILLIAM</u> <u>SR.</u>				2. DATE AND HOUR OF DEATH <u>4/20/72</u> <u>15:35 PM</u> <u>M.</u>					
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>ST AGNES HOSPITAL</u> <u>40</u>				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>HOWARD CO</u> C. CITY OR TOWN <u>BALTIMORE</u> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER <u>3956 OLD COLUMBIA PIKE</u>					
5. SEX <u>MALE</u>		6. RACE <u>CAUCASIAN</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>8 11 20</u>		9. AGE (In years lost birthday) <u>51</u> YRS If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SALES MGR.</u>				10B. KIND OF BUSINESS OR INDUSTRY <u>Edson Cap Toy Co</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>	
13. FATHER'S NAME <u>FERDINAND MAISEL</u>				14. MOTHER'S MAIDEN NAME <u>CORA (CAVEY)</u>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>YES WW2</u>				16. SOCIAL SECURITY NO. <u>220-05-4225</u>		17. INFORMANT <u>ST AGNES HOSP., BALTO., MD.</u>			
18. <u>162.1 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Lung's Cancer</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Lung's Cancer</u>				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Lung's Cancer</u> (B) DUE TO, OR AS A CONSEQUENCE OF: <u>Lung's Cancer</u> (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).									
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>NO</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH? (Notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from <u>4 10 72</u> 19 <u>to</u> <u>4 20</u> 19 <u>72</u> that (IX) (we) last saw the deceased alive on <u>4 20</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (XXXX) view the body after death.									
23A. SIGNATURE <u>Nicholas STRATIGAKIS MD</u> DEGREE				23B. DATE SIGNED <u>4-20-72</u>				23C. PHYSICIAN'S NAME (Type) <u>Nicholas STRATIGAKIS MD</u> DEGREE	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>				24B. DATE <u>4-24-72</u>		24C. NAME of CEMETERY or CREMATORY <u>Meadowridge Mem. Park</u>		24D. LOCATION (City, town, or county) (State) <u>Elkridge, Md.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>APR 25 1972</u>				25B. NAME OF REGISTRAR <u>Barbara J. G. xx</u>		25C. FUNERAL DIRECTOR <u>Slack Funeral Home, Ellicott City, Md. 21045</u>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

7-200 72 03959				BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		REG. NO. 72 03959	
1. NAME OF DECEASED (Type or Print) Fusco, Salvatore J.				2. DATE AND HOUR OF DEATH 4/22/72 - 7:00PM 7:00 P.M.					
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Mercy Hospital 37				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 101					
5. SEX male				6. RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 6-17 -25	
9. AGE (in years last birthday) 46				10. UNDER 1 Yr. Months: Days		11. UNDER 24 Hrs. Hours: Min.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Dispatcher				10B. KIND OF BUSINESS OR INDUSTRY Bay Boats		11. BIRTHPLACE (State or foreign country) Baltimore		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Joseph L. Fusco				14. MOTHER'S MAIDEN NAME Marie C. Newbaur					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) yes WW II				16. SOCIAL SECURITY NO. 219-16-6275		17. INFORMANT Edna Fusco			
18. 441.2 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Coronary artery disease				19. CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: 2% acute myocardial infarction		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 hour			
20. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. 7 days				21. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). II		22. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
19A. DATE OF OPERATION 4/22/72		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED rule exclusion of funeral expenses		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR (If in Baltimore City, give exact location)		21D. TIME OF INJURY (APPROX.)			
21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?		21G. HOW DID INJURY OCCUR?		21H. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 19 to 19 that (I) (we) last saw the deceased alive on April 22, 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.				23A. SIGNATURE Phillip E. Middleton Jr.		23B. DATE SIGNED 4/22/72		23C. PHYSICIAN'S NAME (Type) Phillip E. Middleton Jr.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4/27/72		24C. NAME OF CEMETERY OR CREMATOR Sacred Heart of Jesus		24D. LOCATION (City, town, or county) (State) Balto Md.		25A. DATE REC'D BY HEALTH DEPT. APR 25 1972	
25B. NAME OF REGISTRAR Phillip E. Crach		25C. FUNERAL DIRECTOR 1211 Chicago Ave		25D. ADDRESS 1211 Chicago Ave		25E. ADDRESS 1211 Chicago Ave			

11. 11.

11. 11.

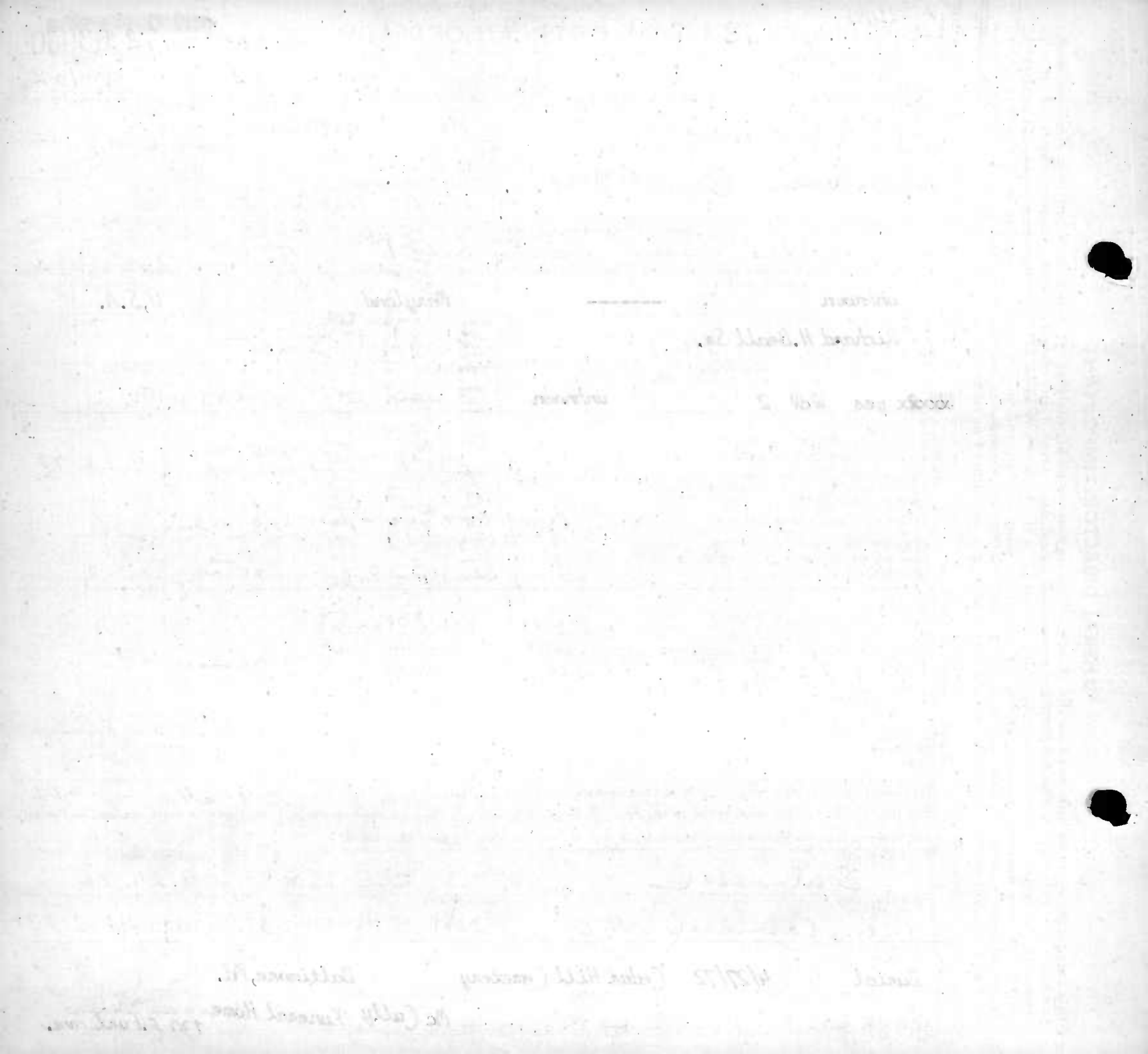
11. 11.

Philip C. Smith to 1932
Bureau of Land Management
Philip C. Smith 1932

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

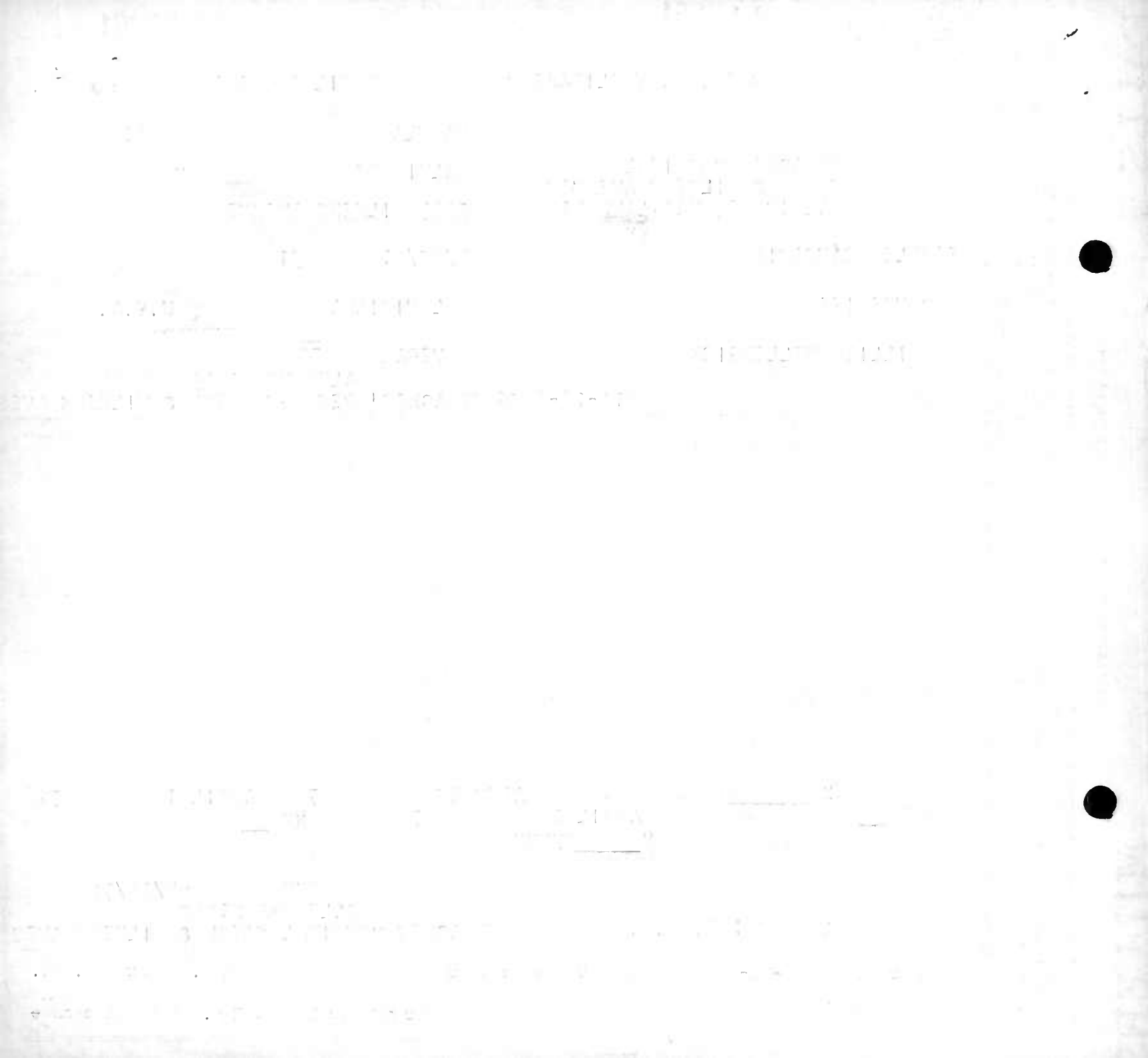
B-400 72 03960				BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 03960	
BIRTH NO.				1. NAME OF DECEASED (Type or Print) <i>Beall Clarence H.</i>		2. DATE AND HOUR OF DEATH <i>4.24.72 10:10 A.M.</i>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>Md.</i> B. COUNTY <i>Baltimore</i>		2303	
FULL NAME OF HOSPITAL OR INSTITUTION <i>S. Baltimore General Hosp.</i>				C. CITY OR TOWN <i>Baltimore</i>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER <i>29 E. Heath St.</i>				5. SEX <i>M.</i>		6. RACE <i>W.</i>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH <i>6.22.14</i>		9. AGE (In years lost birthday) <i>57</i>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>unknown</i>				10B. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>				13. FATHER'S NAME <i>Richard H. Beall (Sec.)</i>		14. MOTHER'S MAIDEN NAME <i>Margaret Smoot</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>WW2 yes WW 2</i>				16. SOCIAL SECURITY NO. <i>unknown</i>		17. INFORMANT <i>Emma Grebeck (sister)</i>	
18. <i>162.1</i> I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). 19A. DATE OF OPERATION <i>14.11.72</i>				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>R. Lung cancer</i>		20A. AUTOPSY? (Yes or No) <i>No</i>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>3.30.72</i> to <i>4.24.72</i> and that (I) (we) last saw the deceased alive on <i>4.24.72</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <i>Salmashi</i>				23B. DATE SIGNED <i>4.24.72</i>		23C. PHYSICIAN'S NAME (Type) <i>G. G. Salmashi, M.D.</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>				24B. DATE <i>4/27/72</i>		24C. NAME OF CEMETERY or CREMATORY <i>Cedar Hill Cemetery</i>	
24D. LOCATION (City, town, or county) <i>Baltimore, Md.</i>				25A. DATE REC'D BY HEALTH DEPT. <i>APR 25 1972</i>		25B. NAME OF REGISTRAR <i>Phyllis J. ...</i>	
25C. FUNERAL DIRECTOR <i>Mc Cully Funeral Home</i>				25D. ADDRESS <i>130 E. Fort Ave.</i>		25E. ...	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

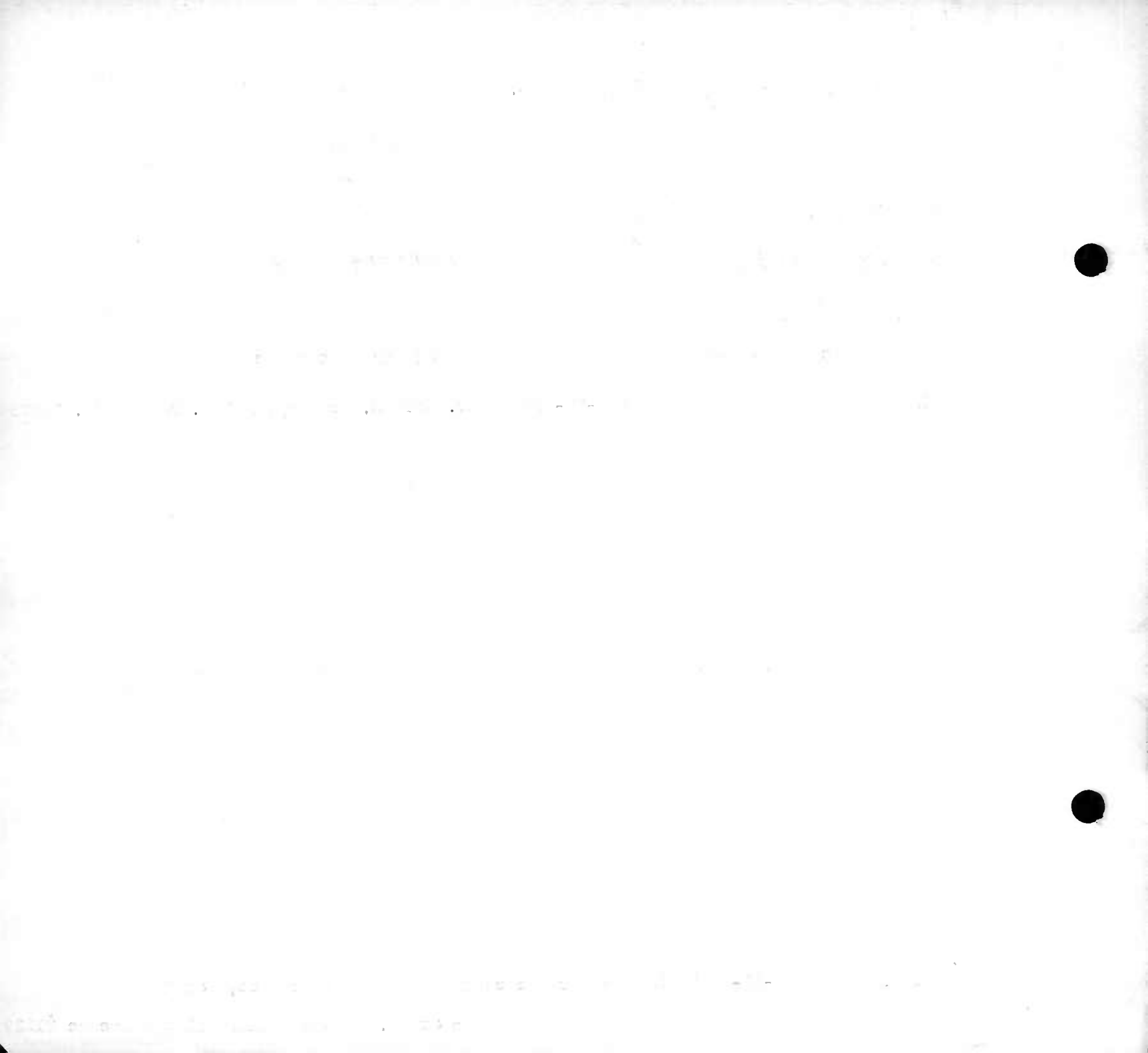
BALTIMORE CITY HEALTH DEPARTMENT				72 03961		72 03961	
BIRTH NO. B-530				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH			
BOHNET, MARY ELIZABETH				APRIL 18, 1972		9:00 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				A. STATE		B. COUNTY	
40 ST AGNES HOSPITAL CATON & WILKENS AVENUES BALTIMORE, MARYLAND 21229				MARYLAND		2551 21229	
				C. CITY OR TOWN		D. INSIDE CITY LIMITS?	
				BALTIMORE		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER			
				3917 WILKENS AVENUE			
5. SEX	6. RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH	9. AGE (In years last birthday)	10. Under 1 Yr. Months	11. Under 24 Hrs. Days
FEMALE	CAUCASIAN	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		03/25/21	51		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
HOUSEWIFE				LOUISIANA		U.S.A.	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
WILLIAM MELLENDICK				VERA McCurrin			
15. Was Deceased Ever In U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT	
NO				219-16-6856		BALTO MD 21229	
				ST AGNES' RECORDS CATON & WILKENS AVES			
18. 396.0 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				CAUSE OF DEATH			
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Heart failure			
ANTECEDENT CAUSES				(B) Rheumatic heart disease c			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(C) Mitral Stenosis, Aortic insuffic.			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
				NO			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR?		(If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					
22. I certify that (X) (this hospital) attended the deceased from MAR 11 19 72 to APRIL 18 19 72 that (X) (we) last saw the deceased alive on APRIL 18 19 72 and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) X view the body after death.							
23A. SIGNATURE Anna Spitz, M.D.				23B. DATE SIGNED			
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
ANNA SPITZ, M.D.				BALTO MD 21229			
				ST AGNES HOSPITAL CATON & WILKENS AVES			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial		4-21-1972		Meadowridge Cemetery		Washington Blvd. Howard Co. Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		25D. ADDRESS	
APR 25 1972		Robert E. Taylor, M.D.		Hubbard Funeral Home Inc.		4107 Wilkens Ave	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-634 72 03962		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		72 03962 REG. NO.	
1. NAME OF DECEASED (Type or Print) Bradley, CLARA E.		2. DATE AND HOUR OF DEATH 4-19-72 9:15 A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 46 Nuthuran Hospital of Maryland (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY 2003 C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 512 S. Payson Street			
5. SEX Female	6. RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-16-14	9. AGE (in years last birthday) 58	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Joseph Handel		14. MOTHER'S MAIDEN NAME Barbara Zeitvogel	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 216-22-3976		17. INFORMANT Mr. Earl E. Bradley, 512 S. Payson St. 21223	
18. 188X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. (A) IMMEDIATE CAUSE CARDIO-PULMONARY ARREST. (B) CA BLADDER WITH METASTASIS. (C) TERMINAL CA.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that the (this hospital) attended the deceased from 4/16 1972 to 4/19 1972 that it (we) last saw the deceased alive on 4/19 1972 and that in (our) opinion death occurred on the date and hour and from the causes stated above, it (We) (did) (did not) view the body after death.					
23A. SIGNATURE [Signature]		23B. DATE SIGNED 4/19/72		23C. PHYSICIAN'S NAME (Type) SEIN LWIN.	
23D. ADDRESS LUTHERAN HOSPITAL.		23E. DEGREE			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4-22-1972		24C. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery	
24D. LOCATION (City, town, or county) Baltimore, Maryland		24E. (State)			
25A. DATE REC'D BY HEALTH DEPT. APR 25 1972		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR Howard H. Hubbard, 4107 Wilkens Avenue 21229	
25D. ADDRESS		25E. (City, town, or county)			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

S-352 72 03963		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 03963	
CERTIFICATE OF DEATH					
1. NAME OF DECEASED (Type or Print) STANCAVITCH, MARY		2. DATE AND HOUR OF DEATH 4-22-72 12.50 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Sinai Hospital of Baltimore, Inc.		4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE MD B. COUNTY Baltimore C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 3638 Malden Ave. 21211			
5. SEX FEMALE	6. RACE CAUC	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-11-13	9. AGE (In years last birthday) 59	10. Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) US.	
12. CITIZEN OF WHAT COUNTRY? U-S.		13. FATHER'S NAME ?		14. MOTHER'S MAIDEN NAME ?	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO.		17. INFORMANT JOSEPH STANCAVITCH (SAME) ADDRESS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxiation, etc. It means the disease, injury or complication which caused death.) GLIOMA OF BRAIN		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: GLIOMA OF BRAIN		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 yr.	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF:		(C) DUE TO, OR AS A CONSEQUENCE OF:	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 4-22-72 to 4-22-72 and that (I) (we) last saw the deceased alive on 4-22-72 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Wiset Tangchai				23B. DATE SIGNED 4-22-72	
23C. PHYSICIAN'S NAME (Type) WISSET TANGCHAI		23D. ADDRESS Sinai Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 4/25/72		24C. NAME OF CEMETERY or CREMATORY LAKEVIEW	
24D. LOCATION BALTO. CO		25A. DATE REC'D BY HEALTH DEPT. APR 25 1972		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.	
25C. FUNERAL DIRECTOR Carl E. Chomicki		25D. ADDRESS 3617 Chestnut Ave.			

1881

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
CERTIFICATE OF DEATH					REG. NO. <u>72 03964</u>				
BIRTH NO. <u>S-460</u> <u>72 03964</u>					1. NAME OF DECEASED (Type or Print) FRANKLIN JOSEPH SCHALLER JR.				
2. DATE AND HOUR OF DEATH 4-19-72 7:30AM M.									
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD					4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)				
FULL NAME OF HOSPITAL OR INSTITUTION THE JOHNS HOPKINS HOSPITAL 33					A. STATE MARYLAND				
					B. COUNTY WASHINGTON 7100				
					C. CITY OR TOWN SMITHSBURG				
					D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
					E. STREET AND NUMBER RT 2				
5. SEX MALE		6. RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 03-9-71		9. AGE (in years last birthday) 1	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME FRANKLIN J. SCHALLER SR.					14. MOTHER'S MAIDEN NAME DONNIE WINDERS				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service				16. SOCIAL SECURITY NO.		17. INFORMANT Mr. Franklin J. Schaller Sr. Smithsburg, Md			
18. 746.3 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Cardiac Arrest ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: VSD ASD (B) DUE TO, OR AS A CONSEQUENCE OF: Hypoxia, post op day (C) hx of CHF since VSD					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 45min				
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).									
19A. DATE OF OPERATION 3/18/72			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED VSD Patent Aortic ASD			20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) 0			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 0			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 0			
21D. TIME OF INJURY (APPROX) 0			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 4/18 19 72 to 4/19 19 72 that (I) (we) last saw the deceased alive on 4/19 19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE Levi Watkins Jr M.D.					Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>			23B. DATE SIGNED 4/19/72	
23C. PHYSICIAN'S NAME (Type) LEVI WATKINS JR. M.D.					23D. ADDRESS THE JOHNS HOPKINS HOSPITAL				
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4-22-1972		24C. NAME OF CEMETERY or CREMATORY Smithsburg Cemetery			24D. LOCATION (City, town, or county) (State) Smithsburg, Wash. Md.		
25A. DATE REC'D BY HEALTH DEPT. APR 25 1972			25B. NAME OF REGISTRAR Roger E. Smith			25C. FUNERAL DIRECTOR Davis Funeral Home Smithsburg, Md.			

MADE:

MADE IN THE U.S.A.

MADE IN THE U.S.A.

MADE IN THE U.S.A.

MADE IN THE U.S.A.

MADE IN THE U.S.A.

MADE IN THE U.S.A.

MADE IN THE U.S.A.

MADE IN THE U.S.A.

MADE IN THE U.S.A.

MADE IN THE U.S.A.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

G-632		72 03965		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 03965	
CERTIFICATE OF DEATH							
1. NAME OF DECEASED (Type or Print) LOUIS J. GRUDZIECKI SR.				2. DATE AND HOUR OF DEATH APRIL 19, 1972			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) CHURCH HOME AND HOSPITAL 35				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY 201 C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 8 SOUTH WASHINGTON ST.			
5. SEX MALE	6. RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/25/1911	9. AGE (In years last birthday) 60 YRS.	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED		10B. KIND OF BUSINESS OR INDUSTRY GENERAL MOTORS		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME JOHN GRUDZIECKI				14. MOTHER'S MAIDEN NAME MARY GRITZKOWSKI			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO.		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS MR JOHN GRUDZIECKI 1636 MAULVERNEA			
18. 162.1 I CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Carcinoma Lung (left) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Advanced (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).							
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 6/19 19 65 to 4/19 19 72 that (I) (we) last saw the deceased alive on 3/9 19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE L. B. Stevens M.D.				Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) L. B. Stevens, M.D.				23D. ADDRESS 3400 Erdman Ave. Balto., Md. 21213			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 4/22/72		24C. NAME OF CEMETERY OR CREMATORY CEDAR HILL CEMETERY		24D. LOCATION (City, town, or county) (State) BALTIMORE CO. MD.	
25A. DATE REC'D BY HEALTH DEPT. APR 25 1972		25B. NAME OF REGISTRAR Robert E. Johnson		25C. FUNERAL DIRECTOR RAYMOND L. KACZOROWSKI		ADDRESS 2525 FLEET ST.	

Carmona Fund (H) (H)

FUNERAL DIRECTOR: IMPORTANT

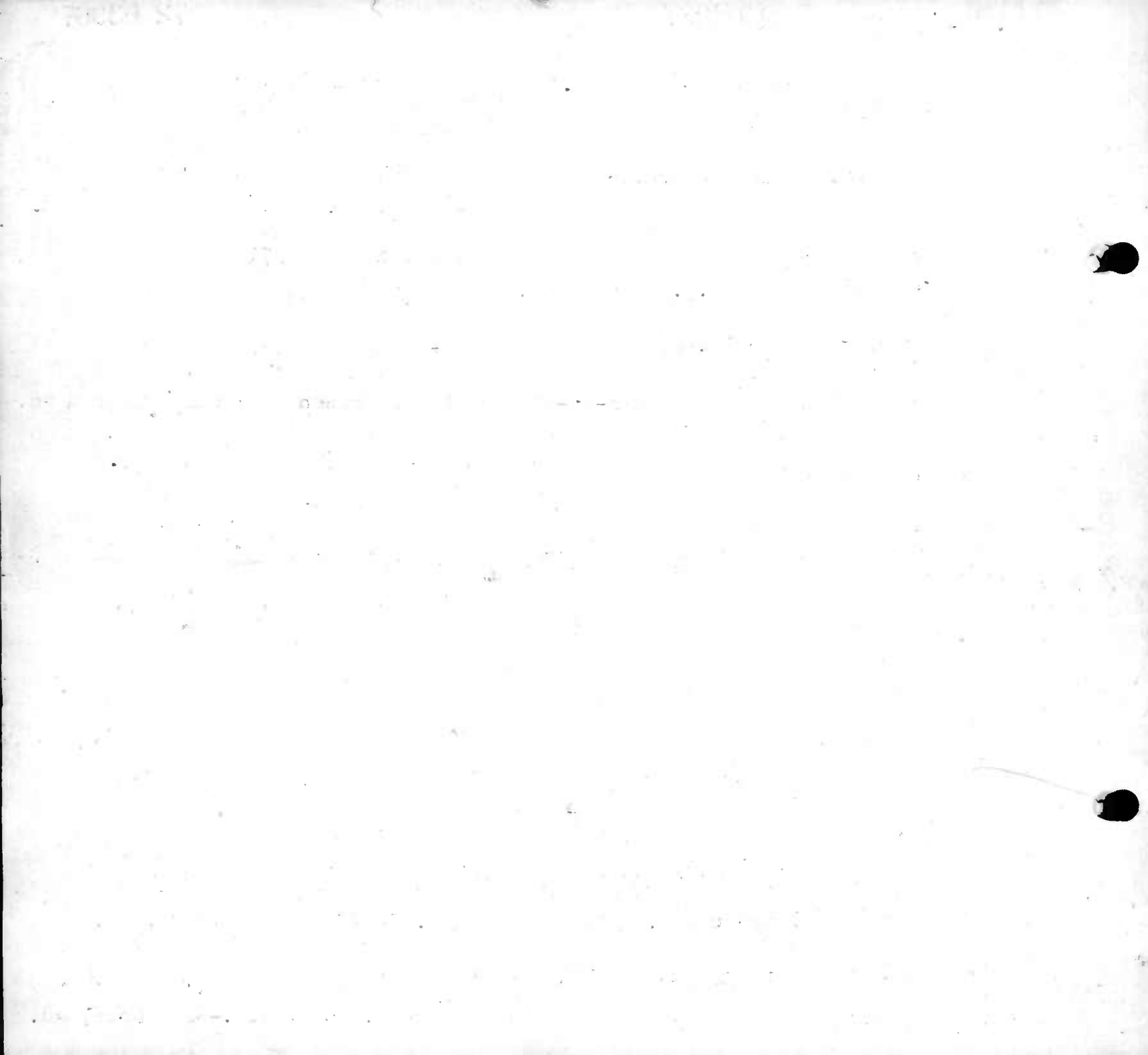
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

G-654		72 03966		BALTIMORE CITY HEALTH DEPARTMENT		X		72 03966	
BIRTH NO.				CERTIFICATE OF DEATH				REG. NO.	
1. NAME OF DECEASED (Type or Print) JAMES GRINNELL				2. DATE AND HOUR OF DEATH 4/18/72 7:00 PM					
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) UNIVERSITY OF MD HOSPITAL				4. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) A. STATE MD. B. COUNTY KENT CO C. CITY OR TOWN ROCKHALL D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER RT. 5 BOX 233					
5. SEX M	6. RACE N	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9-21-29		9. AGE (In years last birthday) 42		If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CONSTRUCTION				10B. KIND OF BUSINESS OR INDUSTRY LABOR		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME HOUSTON GRINNELL				14. MOTHER'S MAIDEN NAME ELSIE BUTLER					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES KOREA				16. SOCIAL SECURITY NO. 215-262024		17. INFORMANT MARYLE BUTLER R.F.D.		ADDRESS ROCKHALL, MD	
18. 430.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CARDIORESPIRATORY ARREST				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: SUBARACHNOID HEMORRHAGE				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH MIN	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. 2				(B) DUE TO, OR AS A CONSEQUENCE OF: 2 wks.					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).									
19A. DATE OF OPERATION 4/16/72		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED SUBARACHNOID HEMORR.		20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (this hospital) attended the deceased from 4/18 19 72 to 4/18 19 72 that (we) last saw the deceased alive on 4/18 19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (did not) view the body after death.									
23A. SIGNATURE L.B. Barnett MD				23B. DATE SIGNED 4/18/72				23C. PHYSICIAN'S NAME (Type) L.B. BARNETT MD	
23D. ADDRESS UNIVERSITY HOSP.				23E. FUNERAL DIRECTOR Kenneth W. Chastel					
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 4/22/72		24C. NAME OF CEMETERY OR CREMATORY AARON CHAVE CEM.		24D. LOCATION (City, town, or county) (State) ROCKHALL KENT MD			
25A. DATE REC'D BY HEALTH DEPT. APR 25 1972		25B. NAME OF REGISTRAR Robert E. Taylor MD		25C. FUNERAL DIRECTOR Kenneth W. Chastel					

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Baltimore City Health Department				BIRTH NO.		72 03967		CERTIFICATE OF DEATH		72 03967	
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH				3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			
JOHN WALTER HARRISON				April 25, 1972				00 2921 Glenmore Avenue			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE B. COUNTY				5. SEX male			
Maryland				Baltimore				6. RACE caucasian			
2921 Glenmore Ave.				C. CITY OR TOWN Baltimore				7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				E. STREET AND NUMBER 2921 Glenmore Ave.				8. DATE OF BIRTH July 26, 1899			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY				9. AGE (In years lost birthday)			
U.S. Postal Dept. retired				Oxford, Maryland				71			
11. BIRTHPLACE (State or foreign country)				12. CITIZEN OF WHAT COUNTRY?				13. FATHER'S NAME			
USA				USA				Samuel Richard Harrison			
14. MOTHER'S MAIDEN NAME				15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
Nina Estella Timmons				yes WW I				213-36-8001			
17. INFORMANT				18. CAUSE OF DEATH				19. DATE OF OPERATION			
Walter Harrison (son) 6211 Pilgrim Rd.				DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) 412.3 I Congestive Heart Failure APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 yrs				20A. AUTOPSY? (Yes or No)			
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				21D. TIME OF INJURY (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
21F. HOW DID INJURY OCCUR?				22. I certify that (I) (this hospital) attended the deceased from 19 65 to 19 72, that (I) (we) last saw the deceased alive on March 11, 19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				23A. SIGNATURE Dr. Francis T. Daly			
23B. DATE SIGNED April 25, 1972				23C. PHYSICIAN'S NAME (Type) Dr. Francis T. Daly				23D. ADDRESS 11 E. Chase St, Baltimore, Md.			
24A. BURIAL CREMATION, REMOVAL (Specify) burial				24B. DATE 4/28/72				24C. NAME OF CEMETERY or CREMATORY Moreland Memorial			
24D. LOCATION (City, town, or county) (State) Baltimore, Md.				25A. DATE REC'D BY HEALTH DEPT. APR 26 1972				25B. NAME OF REGISTRAR Robert E. Fisher, M.D.			
25C. FUNERAL DIRECTOR Leonard J. Ruck, Inc.-Baltimore, Md.				25D. ADDRESS				25E. DATE			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 03968	
BIRTH NO. 1. NAME OF DECEASED (Type or Print)		CERTIFICATE OF DEATH			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		2. DATE AND HOUR OF DEATH 4/24/72			
3206 Rosalie Ave.		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Md. B. COUNTY			
5. SEX F.		6. RACE W.		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Sweden	
13. FATHER'S NAME Olaf Nelson		14. MOTHER'S MAIDEN NAME Britta Olsen			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 220-46-9571		17. INFORMANT Gustave Dahlstrom same	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Cerebrovascular accident (B) DUE TO, OR AS A CONSEQUENCE OF: Cerebral artery occlusion (C) Generalized arteriosclerosis		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH few hrs. 20 yrs. 20 yrs.	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>any</u> 19 <u>66</u> to <u>April</u> 19 <u>72</u> , that (I) (we) last saw the deceased alive on <u>March 15</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date <u>and hour</u> and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE 				23B. DATE SIGNED 4/24/72	
23C. PHYSICIAN'S NAME (Type) S. Elliott Harris MD.				23D. ADDRESS 8100 Harford Rd. Balto. Md.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4/27/72		24C. NAME of CEMETERY or CREMATORY Lorraine Park	
24D. LOCATION (City, town, or county) (State) Balto. Md.		25A. DATE REC'D BY HEALTH DEPT. APR 26 1972			
25B. NAME OF REGISTRAR Robert E. Fisher, Jr.		25C. FUNERAL DIRECTOR Leonard J. Ruck Inc. Balto. Md.			

12/10/1987

Sweden

Private letter

12/10/1987 - 12/10/1987

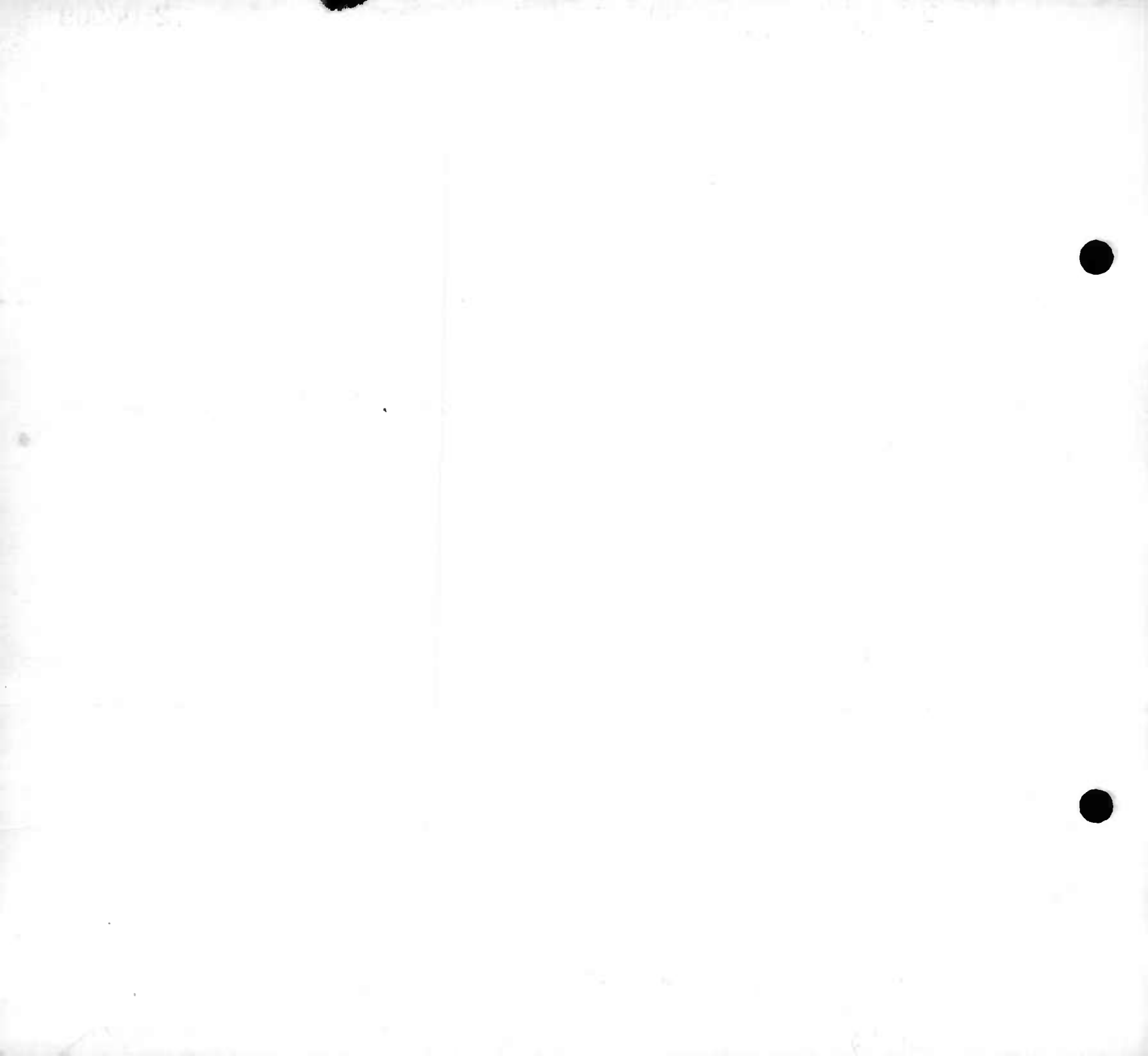
1. Letter dated 12/10/1987

2. Letter dated 12/10/1987

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				72 03969	
CERTIFICATE OF DEATH				REG. NO. _____	
1. NAME OF DECEASED (Type or Print) <u>Howard Lillian</u>		2. DATE AND HOUR OF DEATH <u>4/23/72</u> <u>11:10</u> A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <u>South Baltimore General Hospital</u>		A. STATE <u>Maryland</u>		B. COUNTY <u>21225</u>	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <u>F</u>		6. RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	
8. DATE OF BIRTH <u>11-27-05</u>		9. AGE (in years last birthday) <u>66</u>		10. WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY <u>U. S. A</u>		13. FATHER'S NAME <u>John Baumann</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>217-32-8386-A</u>		17. INFORMANT <u>Jesse P. Howard</u>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>410.9 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <u>Intense Myocardial Infarction</u>		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>II</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <u>Coronary vascular disease</u>		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		(B) _____	
(C) _____		(D) _____		(E) _____	
MEDICAL CERTIFICATION		19A. DATE OF OPERATION <u>0</u> <u>nil</u>			
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>nil</u>		20A. AUTOPSY? (Yes or No) <u>nil</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <u>nil</u>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>nil</u>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) <u>---</u>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>4/21/72</u> 19 <u>72</u> to <u>4/23/72</u> 19 <u>72</u> that (I) (we) last saw the deceased alive on <u>4/23/72</u> 19 <u>72</u> and that (n) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Sirithara</u>		DEGREE <u>M.D.</u>		23B. DATE SIGNED <u>4/25/72</u>	
23C. PHYSICIAN'S NAME (Type) <u>SIRITHARA</u>		23D. ADDRESS <u>South Baltimore General Hospital</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>4/27/72</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>	
24D. LOCATION <u>Ritchie Hwy Balto Md. 21225</u>		25A. DATE REC'D BY HEALTH DEPT. <u>APR 26 1972</u>			
25B. NAME OF REGISTRAR <u>Robert E. Farber, M.D.</u>		25C. FUNERAL DIRECTOR <u>McJully Funeral Home</u>			
25D. ADDRESS <u>237 Patapaco Ave</u>					



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

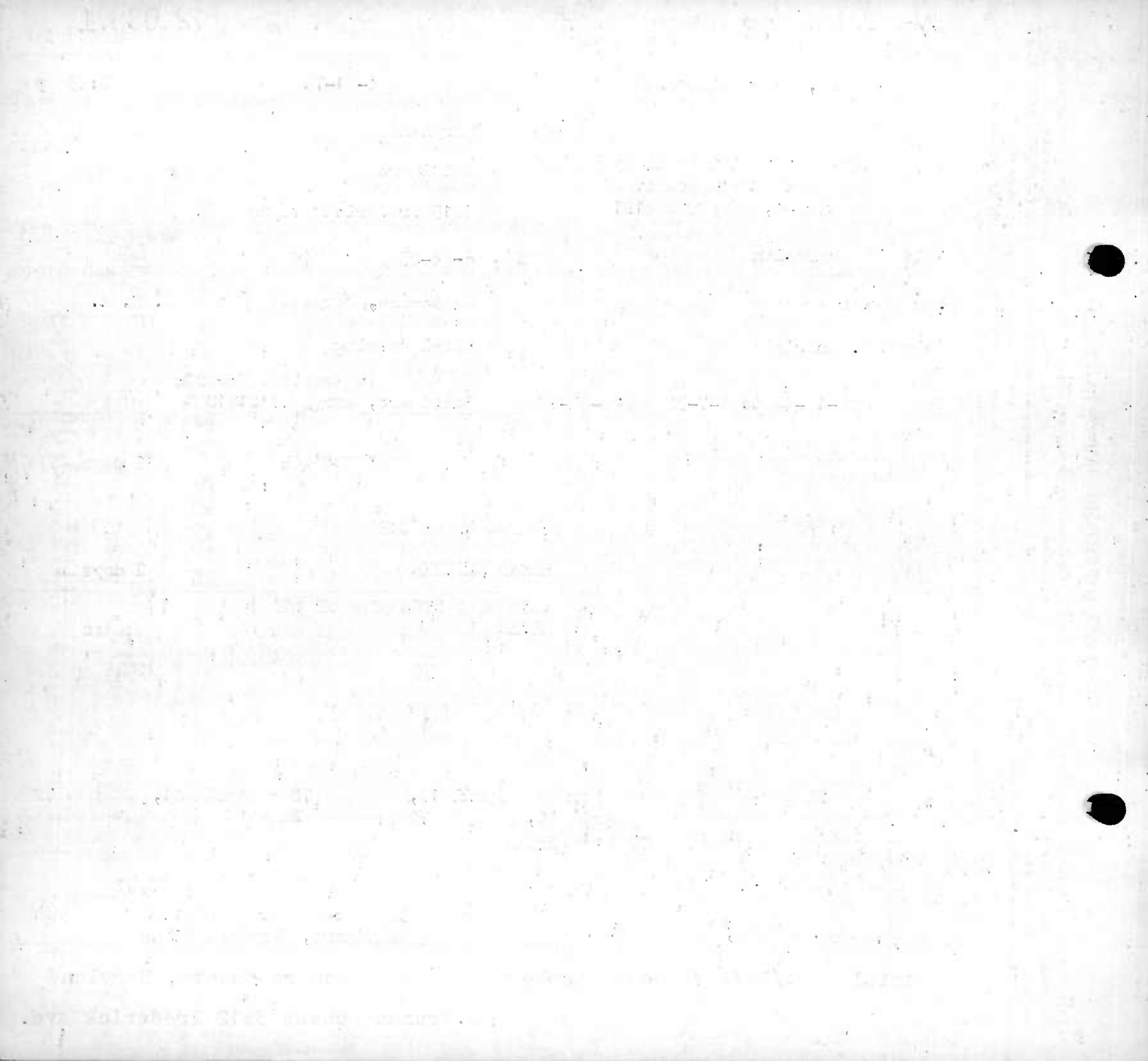
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>72 03970</u>	
BIRTH NO. <u>H-512</u> <u>72 03970</u>				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <u>Regina Irene Heimbuch</u>			2. DATE AND HOUR OF DEATH <u>April 23, 1972</u> <u>6:30 P</u> M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>90 Hood Nursing Home</u>			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Md.</u> B. COUNTY <u>2743</u> C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>4621 Arabia Avenue</u>		
5. SEX <u>Female</u>	6. RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10/20/88</u>	9. AGE (In years last birthday) <u>83</u>	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			10B. KIND OF BUSINESS OR INDUSTRY <u>Homemaker</u>		
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>Otto Kahn</u>			14. MOTHER'S MAIDEN NAME <u>Johanna Rieber</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>			16. SOCIAL SECURITY NO. <u>212-30-5406A</u>		
17. INFORMANT <u>Mrs. Virginia H. Bailey</u>			ADDRESS <u>21214 4621 Arabia Ave. Balto</u>		
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Seconds</u> <u>1 day</u>
19A. DATE OF OPERATION <u>4/22</u>			20A. AUTOPSY? (Yes or No) <u>No</u>		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from <u>4/22</u> 19 <u>72</u> to <u>4/23</u> 19 <u>72</u> that (H) (we) last saw the deceased alive on <u>4/22</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (H) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>James J. Nolan</u>			23B. DATE SIGNED <u>4/25/72</u>		
23C. PHYSICIAN'S NAME (Type) <u>J. J. NOLAN</u>			23D. ADDRESS <u>Baltimore Md 21229</u>		
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>4/26/72</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Oaklawn Cemetery</u>	
24D. LOCATION <u>Baltimore Balto.</u>		24E. STATE <u>Md.</u>		24F. ADDRESS <u>21236</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>APR 26 1972</u>		25B. NAME OF REGISTRAR <u>Charles E. Bailey, Jr.</u>		25C. FUNERAL DIRECTOR <u>Lassahn Funeral Home</u>	
25D. ADDRESS <u>7401 Belair Rd. Balto.</u>		25E. ADDRESS <u>21236</u>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Baltimore City Health Department				REG. NO. <u>72 03971</u>	
11-620		72 03971		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) MORRIS, James Ellsworth			2. DATE AND HOUR OF DEATH 4-21-72 8:45 p.m.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 2531		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Veterans Administration Hospital 3900 Loch Raven Boulevard Baltimore, Maryland 21218			C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
E. STREET AND NUMBER 4813 Frederick Avenue					
5. SEX Male	6. RACE Caucasian	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 6-24-29	9. AGE (In years last birthday) 42	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bar Tender		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland	
13. FATHER'S NAME Robert L. Morris			12. CITIZEN OF WHAT COUNTRY? U. S. A.		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes 5-19-48 to 4-7-52			16. SOCIAL SECURITY NO. 220-22-7228		17. INFORMANT VA Hospital Records Baltimore, Maryland 21218
18. 593.2 I 4 571.0 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) BRONCHOPNEUMONIA (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: PERITONEAL ABSCESS (B) DUE TO, OR AS A CONSEQUENCE OF: RENAL FAILURE (C) DUE TO, OR AS A CONSEQUENCE OF: ALCOHOLIC CIRRHOSIS OF THE LIVER			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 days (?) (?) 2 days Years		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that XX (this hospital) attended the deceased from April 18, 1972 to April 21, 1972 , that XX (we) last saw the deceased alive on April 21, 1972 and that in XX (our) opinion death occurred on the date and hour and from the causes stated above. XX (We) (did) XXXX view the body after death.					
23A. SIGNATURE William A. Stuart M.D.				23B. DATE SIGNED 4/22/72	
23C. PHYSICIAN'S NAME (Type) WILLIAM A. STUART, M.D.				23D. ADDRESS 3900 Loch Raven Boulevard Baltimore, Maryland 21218	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4/24/1972		24C. NAME of CEMETERY or CREMATORY Good Shepherd	
24D. LOCATION Howard County, Maryland		24E. DATE REC'D BY HEALTH DEPT.			
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR G. Truman Schwab	
25D. ADDRESS 3512 Frederick Ave.					



1. NAME OF DECEASED (Type or Print)		2. DATE OF DEATH		3. DATE PRONOUNCED DEAD		4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		6. SEX		7. RACE		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		9. DATE OF BIRTH		10. AGE (In years last birthday)		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		15. MOTHER'S MAIDEN NAME		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO.		18. INFORMANT ADDRESS		19. CAUSE OF DEATH		20. DATE OF OPERATION		21. AUTOPSY? (Yes or No)		22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		22D. TIME OF INJURY (Approx.)		22E. INJURY OCCURRED		22F. HOW DID INJURY OCCUR?		23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		ACTUAL EXAMINER'S NAME (Type)		24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)		25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
ALICE MADDOX		Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/>		Month Day Year April 19, 1972		M. April 19, 1972		Hour 11:54 A.M.		Female		Negro		MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		Jan. 1, 1927		45		Virginia		U.S.A.		George West		Domestic		Bertie Gordy		no		212 22 4738		Frank Maddox 1700 E. 31st St Balto., Md.		Chronic lung disease with pneumonitis		2		Yes		UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		home, farm, factory, street, office bldg., etc.)		INJURY OCCUR?		m. WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?		I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		Charles S. Springate, M.D.		Burial		April 23, 1972		Accomac		Accomac, Virginia		APR 26 1972		Robert E. Taylor, M.D.		Samuel Savage		New Church, Va.			

97150 97

97150 97

UNITED STATES DEPARTMENT OF AGRICULTURE

1915

1915

UNITED STATES DEPARTMENT OF AGRICULTURE
BUREAU OF PLANT INDUSTRY

1915

1915

1915

UNITED STATES DEPARTMENT OF AGRICULTURE

BUREAU OF PLANT INDUSTRY

1915

1915

UNITED STATES DEPARTMENT OF AGRICULTURE

BUREAU OF PLANT INDUSTRY

1915

UNITED STATES DEPARTMENT OF AGRICULTURE

BUREAU OF PLANT INDUSTRY

1915

UNITED STATES DEPARTMENT OF AGRICULTURE

BUREAU OF PLANT INDUSTRY

1915

UNITED STATES DEPARTMENT OF AGRICULTURE

BUREAU OF PLANT INDUSTRY

1915

UNITED STATES DEPARTMENT OF AGRICULTURE

BUREAU OF PLANT INDUSTRY

1915

UNITED STATES DEPARTMENT OF AGRICULTURE

BUREAU OF PLANT INDUSTRY

1915

UNITED STATES DEPARTMENT OF AGRICULTURE

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. <u>72 03973</u>
<u>W-400</u> BIRTH NO. <u>72 03973</u> 1. NAME OF DECEASED (Type or Print) <u>Edith Willey</u>		2. DATE AND HOUR OF DEATH <u>April 23, 1972</u> <u>9:30 A.M.</u>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <u>90</u> (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>Century Home, Inc.</u> <u>102 N. Paca Street</u> <u>Baltimore, Maryland</u>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>2610</u> C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>3206 E. Fairmount Avenue</u>		
5. SEX <u>F</u>	6. RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1/11/96</u> '96	9. AGE (In years last birthday) <u>76</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Seamstress</u>		10B. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
13. FATHER'S NAME <u>William M. Jones</u>		14. MOTHER'S MAIDEN NAME <u>Annabelle Freeman</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>218-18-4555</u>		
17. INFORMANT <u>Mr. Charles R. Willey</u>		ADDRESS <u>3206 E. Fairmount Avenue</u>		
18. <u>472.4 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) slowing the UNDERLYING CONDITION last.		CAUSE OF DEATH <u>Cardio Respiratory Failure</u> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Arteriosclerosis C.V.H.</u> (B) <u>Parkinson's Disease</u> DUE TO, OR AS A CONSEQUENCE OF: (C) <u>Diabetes Mellitus</u>		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from <u>JAN 4</u> 19 <u>72</u> to <u>April 23</u> 19 <u>72</u> that (I) (we) last saw the deceased alive on <u>Apr 23</u> 19 <u>72</u> and that in (my) <u>last</u> opinion death occurred on the date and hour and from the causes stated above. (I) (<u>did not</u>) view the body after death.				
23A. SIGNATURE <u>William D Appleford</u>				23B. DATE SIGNED
23C. PHYSICIAN'S NAME (Type) <u>William D Appleford</u>		23D. ADDRESS <u>6615 Reisterstown Rd</u>		
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>4/25/72</u>		24C. NAME of CEMETERY or CREMATORY <u>Poplar Grove Cemetery</u>
24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>		25A. DATE REC'D BY HEALTH DEPT. <u>APR 26 1972</u>		
25B. NAME OF REGISTRAR <u>John E. Taylor, M.D.</u>		25C. FUNERAL DIRECTOR <u>John A. Moran, Inc.</u>		
ADDRESS <u>3000 E. Baltimore St.</u>				



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				CERTIFICATE OF DEATH		REG. NO. 72 03974	
V-420 BIRTH NO.		72 03974					
1. NAME OF DECEASED (Type or Print) ADDIE JOSEPHINE VELOZ				2. DATE AND HOUR OF DEATH 4-21-72		4:45 P M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION THE JOHNS HOPKINS HOSPITAL				A. STATE MARYLAND B. COUNTY BALTO. CO.			
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				C. CITY OR TOWN BALTIMORE DUNDALK		D. INSIDE CITY LIMITS? NO	
				E. STREET AND NUMBER 7114 SOLLERS POINT RD.			
5. SEX FEMALE	6. RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9-1-18	9. AGE (In years last birthday) 53	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MACHINE OPERATOR		10B. KIND OF BUSINESS OR INDUSTRY PLASTICS		11. BIRTHPLACE (State or foreign country) GEORGIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME SAINTS, GEORGE W.				14. MOTHER'S MAIDEN NAME MYRA FLOYD			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 217-05-7797		17. INFORMANT ERNEST VELOZ		ADDRESS 7114 SOLLERS PT. RD. DUNDALK Md. 21222	
18. 162-1-1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) lung cancer				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: lung cancer		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 week.	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) DUE TO, OR AS A CONSEQUENCE OF:			
(C) _____							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). none							
19A. DATE OF OPERATION 4/13/72		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED lung cancer		20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH? <input type="checkbox"/> Notify medical examiner		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 4/11 19 72 to 4/21 19 72 that (I) (we) last saw the deceased alive on 4/21 19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Edward N. Luthers M.D.				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 4/21/72	
23C. PHYSICIAN'S NAME (Type) EDWARD N. LUTHERS M.D.				23D. ADDRESS JOHNS HOPKINS			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE 4/24/72		24C. NAME OF CEMETERY OR CREMATORY Holly Hill		24D. LOCATION (City, town, or county) (State) Balto. Co. Md.	
25A. DATE REC'D BY HEALTH DEPT. APR 26 1972		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR W. Arthur Bradley		ADDRESS Dundalk, Md.	

100-1-18

THE JONES DIXIE HOSPITAL

53

0-1-18

TYPE 1-18

THE JONES DIXIE HOSPITAL

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <i>Gordon R. Nichols</i>		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input checked="" type="checkbox"/> 4 22 72 8 12 P.M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <i>00 106 E Gittings st</i>		3. DATE PRONOUNCED DEAD Month Day Year Hour <i>4 22 72 8 12 P.M.</i>	
6. SEX <i>M</i>		7. RACE <i>Cauc</i>	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <i>Balto</i>	
9. DATE OF BIRTH <i>Feb 29, 1912</i>		10. AGE (In years last birthday) <i>60</i>	
11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Clerk</i>		14B. KIND OF BUSINESS OR INDUSTRY <i>Russell Steel Co.</i>	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		17. SOCIAL SECURITY NO. <i>212010809</i>	
15. MOTHER'S MAIDEN NAME <i>Maggie Flemming</i>		18. INFORMANT <i>Richard J. Nichols</i>	
19. <i>571.8</i>		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Fatty atterction of liver</i> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)		DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).	
20A. DATE OF OPERATION <i>2</i>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22D. TIME (Month) (Day) (Year) (Hour) (Approx.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?		22F. HOW DID INJURY OCCUR?	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>	
ACTUAL SIGNATURE EXAMINER'S NAME (Type) <i>Wetner U. Spitz</i>		DATE SIGNED <i>4.23.72</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>4/26/72</i>	
24C. NAME OF CEMETERY or CREMATORY <i>Western Cemetery</i>		24D. LOCATION (City, town, or county) (State) <i>Baltimore, Maryland</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>APR 26 1972</i>		25B. NAME OF REGISTRAR <i>Robert E. Fisher, M.D.</i>	
25C. FUNERAL DIRECTOR <i>George J. Gonce</i>		25D. ADDRESS <i>4001 Ritchie Hwy Balto, Md 21225</i>	

15 0213

1 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60 61 62 63 64 65 66 67 68 69 70 71 72 73 74 75 76 77 78 79 80 81 82 83 84 85 86 87 88 89 90 91 92 93 94 95 96 97 98 99 100

Concord, N.H.

100 E. Githin Road

100 E. Githin Road

100 E. Githin Road

Fall Collection 17
Nixon

100 E. Githin Road

100 E. Githin Road

100 E. Githin Road

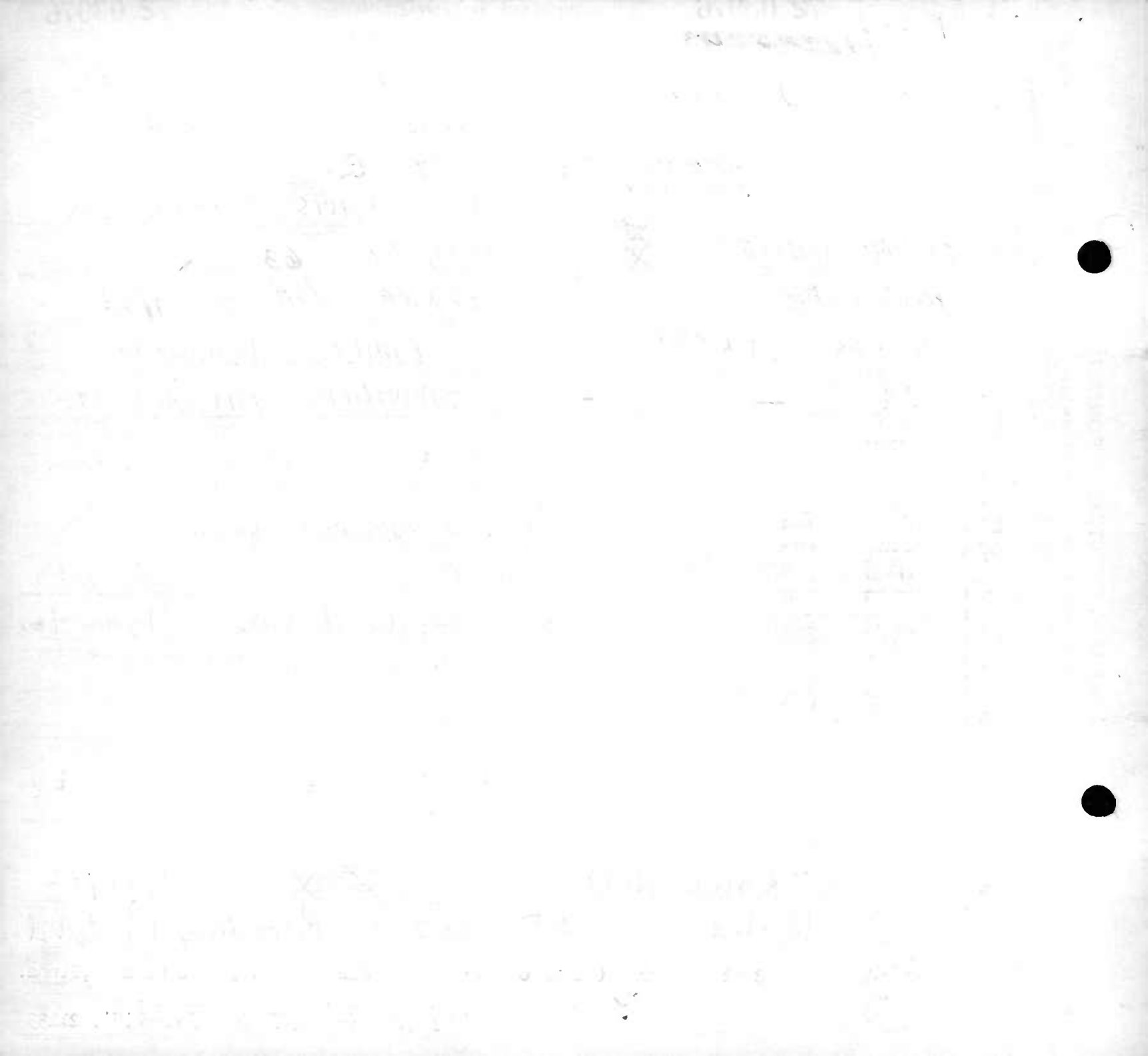
100 E. Githin Road

100 E. Githin Road

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

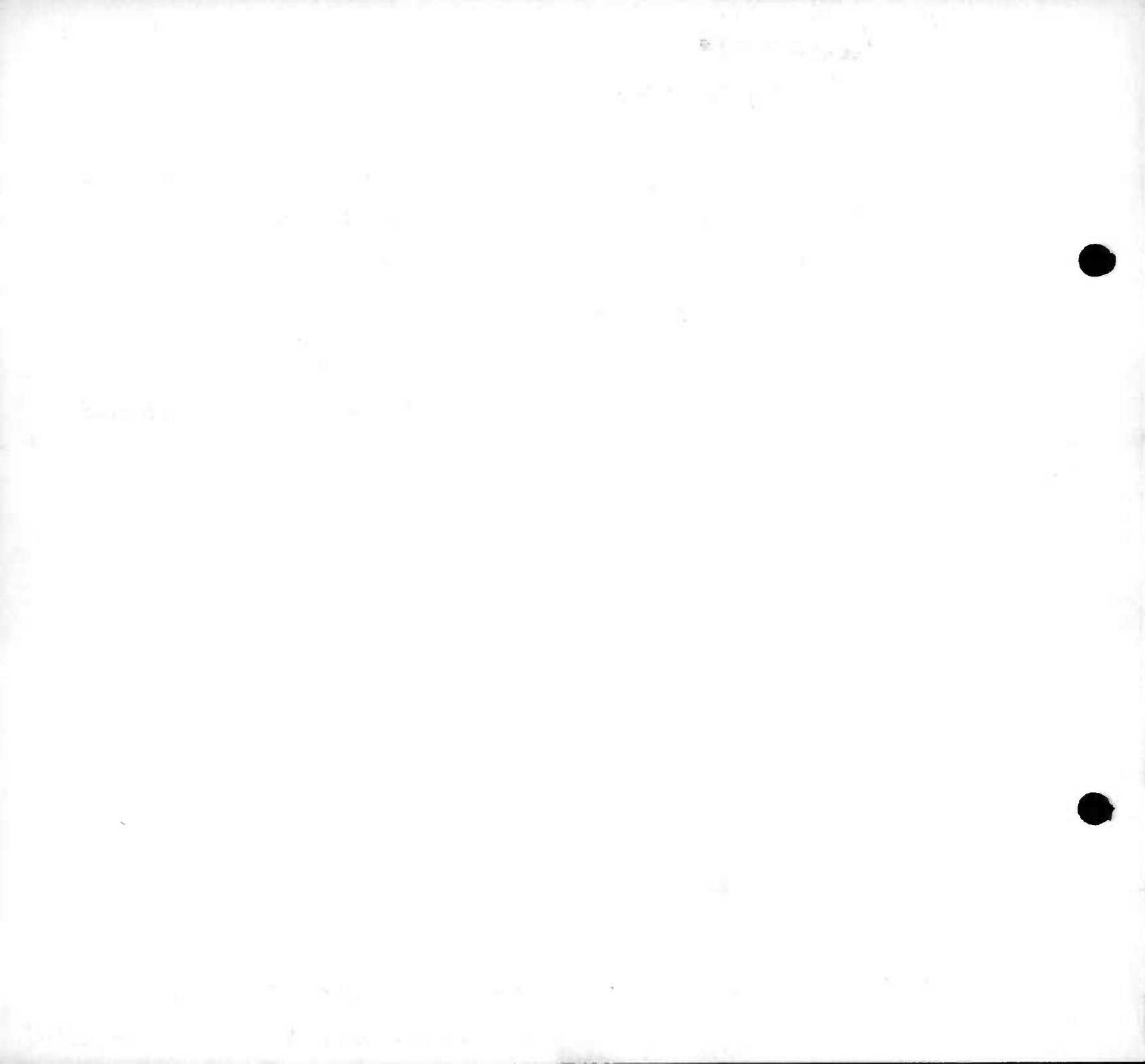
BALTIMORE CITY HEALTH DEPARTMENT				72 03976
CERTIFICATE OF DEATH				REG. NO.
1. NAME OF DECEASED (Type or Print) Russell, Erma		2. DATE AND HOUR OF DEATH 4-22-72 15¹⁵ AM		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 33 IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION JOHNS HOPKINS HOSPITAL 601 N. BROADWAY		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE PENNA B. COUNTY CAMBRIA C. CITY OR TOWN NANTY-GL D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 1315 DAVIS STREET 15943		
5. SEX FEMALE	6. RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov 23, 1908	9. AGE (in years last birthday) 63
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) PENNA USA
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME GEORGE FRESH		
14. MOTHER'S MAIDEN NAME EMILY DIAMOND		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		
16. SOCIAL SECURITY NO. -		17. INFORMANT DAUGHTER ADDRESS 1315 DAVIS ST.		
18. 410.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Ventricular Asystole (B) Presumed myocardial infarction DUE TO, OR AS A CONSEQUENCE OF: (C) ASCVD		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 min 10 hr many yr.
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). Sepsis, Hepatic Failure		18 mos - 1 yr		
19A. DATE OF OPERATION 1		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY (Yes or No) Yes
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (1) (this hospital) attended the deceased from 4/19 to 4/22 19 72 and that (2) (we) last saw the deceased alive on 4/22 19 72 and that (3) (my) (our) opinion death occurred on the date and hour and from the causes stated above (1) (We) (did) (did not) view the body after death.				
23A. SIGNATURE W. Rohde MD		23B. DATE SIGNED 4/22/72		23C. PHYSICIAN'S NAME (Type) Rohde MD
23D. ADDRESS 601 N. Broadway Balt Md		24A. BURIAL CREMATION, REMOVAL (Specify) Removal		
24B. DATE 4/22/72		24C. NAME OF CEMETERY OR CREMATORY Wesley Chapel Cemetery		24D. LOCATION (City, town, or county) (State) Jackson TWSP, RDL Conemaugh, Penna.
25A. DATE REC'D BY HEALTH DEPT. APR 26 1972		25B. NAME OF REGISTRAR Robert E. Taylor, R.D.		25C. FUNERAL DIRECTOR Loring Byers Funeral Directors P.A. ADDRESS 8728 Liberty Road, Randallstown, Md. 21133



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

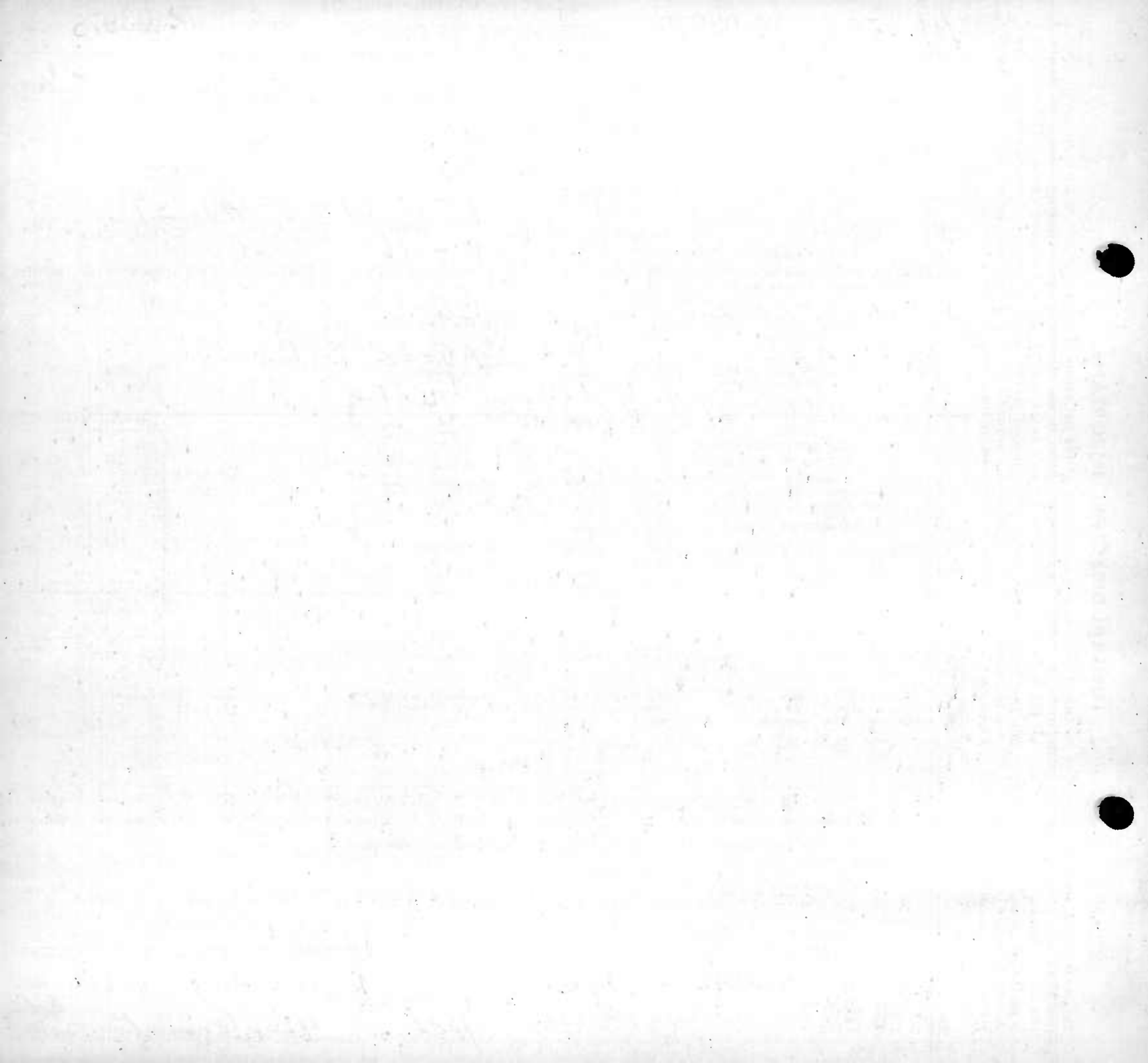
E-231 72 03977		BALTIMORE CITY HEALTH DEPARTMENT	
BIRTH NO. [REDACTED]		CERTIFICATE OF DEATH X REG. NO. 72 03977	
1. NAME OF DECEASED (Type or Print) ESTEP, REDMOND		2. DATE AND HOUR OF DEATH 4/23/72 12:25 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD B. COUNTY BALTO	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) NORTH CHARLES GENERAL HOSP. 2724 NORTH CHARLES STREET BALTO, MD 21218		C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX M 6. RACE W 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		E. STREET AND NUMBER 111 N. MARLIN AVE.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		8. DATE OF BIRTH 3-22-12 9. AGE (In years last birthday) 60	
10B. KIND OF BUSINESS OR INDUSTRY STEEL		11. BIRTHPLACE (State or foreign country) KY	
13. FATHER'S NAME JAMES ESTEP		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		14. MOTHER'S MAIDEN NAME SADIE STAMBAUGH	
16. SOCIAL SECURITY NO. 213-07-7424		17. INFORMANT SARAH ESTEP ADDRESS ABOVE	
18. 398X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 19 hrs. year. 45 years.	
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 4/22 19 72 to 4-23 19 72 that (I) (we) last saw the deceased alive on 4-23 19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE Veena Sathirakul M.D.		23B. DATE SIGNED 4/23/72	
23C. PHYSICIAN'S NAME (Type) VEENA SATHIRAKUL M.D.		23D. ADDRESS NORTH CHARLES GEN HOSP	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 4/26/72	
24C. NAME of CEMETERY or CREMATORY DAK LAWN		24D. LOCATION (City, town, or county) (State) BALTO. MD	
25A. DATE REC'D BY HEALTH DEPT. APR 26 1972		25B. NAME OF REGISTRAR John J. Kelly	
25C. FUNERAL DIRECTOR John J. Kelly		ADDRESS 2002 Maple Ave	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

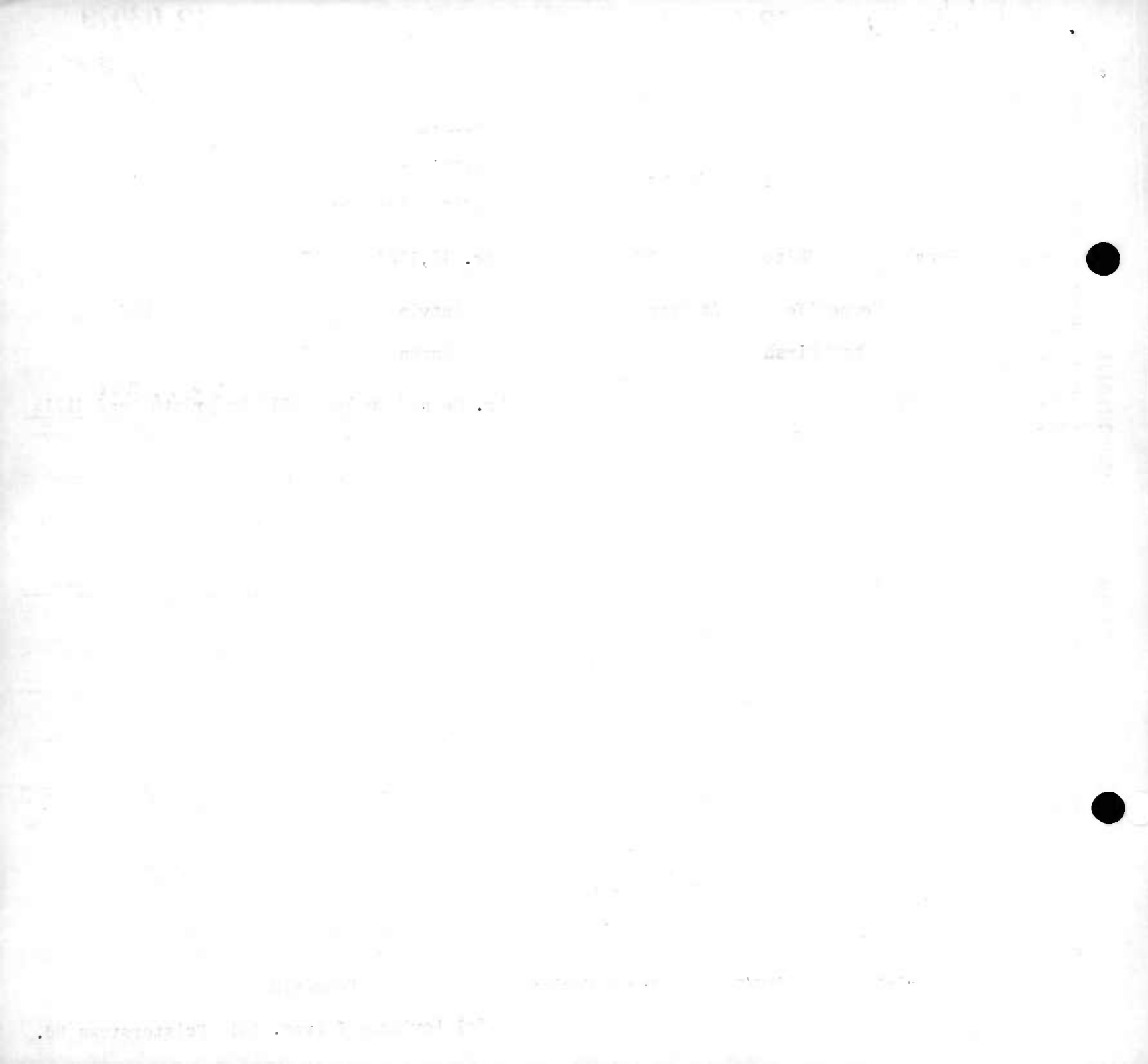
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 03978	
M-453 72 03978				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) JOSEPH T. MALENDIA		2. DATE AND HOUR OF DEATH APRIL 24, 1972 10⁵⁵ A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) SOUTH BALTIMORE GEN. HOSPITAL			4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE MD. B. COUNTY 2505 C. CITY OR TOWN BALTO. D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 1513 OLMSTEAD ST		
5. SEX MALE	6. RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-4-16	9. AGE (In years last birthday) 56	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Longshore man		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) BALTO.	
13. FATHER'S NAME Michael		14. MOTHER'S MAIDEN NAME ADELA BIBICK		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes 1/44 - 1/46		16. SOCIAL SECURITY NO. 213-01-6055		17. INFORMANT Wife	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) MARKED Dehydration LIVER'S CIRRHOSIS posible Hepatoma			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
19A. DATE OF OPERATION 0			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 4-22 19 72 to 4-24 19 72 , that (I) (we) first saw the deceased alive on 4-24 19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Nelson R. DeLara			23B. DATE SIGNED 4/24/72		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>
23C. PHYSICIAN'S NAME (Type) NELSON R-DE LARA			23D. ADDRESS South Balt. Gen. Hospital		
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL	24B. DATE 4-27-72	24C. NAME OF CEMETERY or CREMATORY HOLY-CROSS		24D. LOCATION (City, town, or county) (State) Ritchie Hwy BALTO. MD	
25A. DATE REC'D BY HEALTH DEPT. APR 26 1972		25B. NAME OF REGISTRAR John A. Hahn		25C. FUNERAL DIRECTOR ADDRESS 4200 Pennington 21246	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

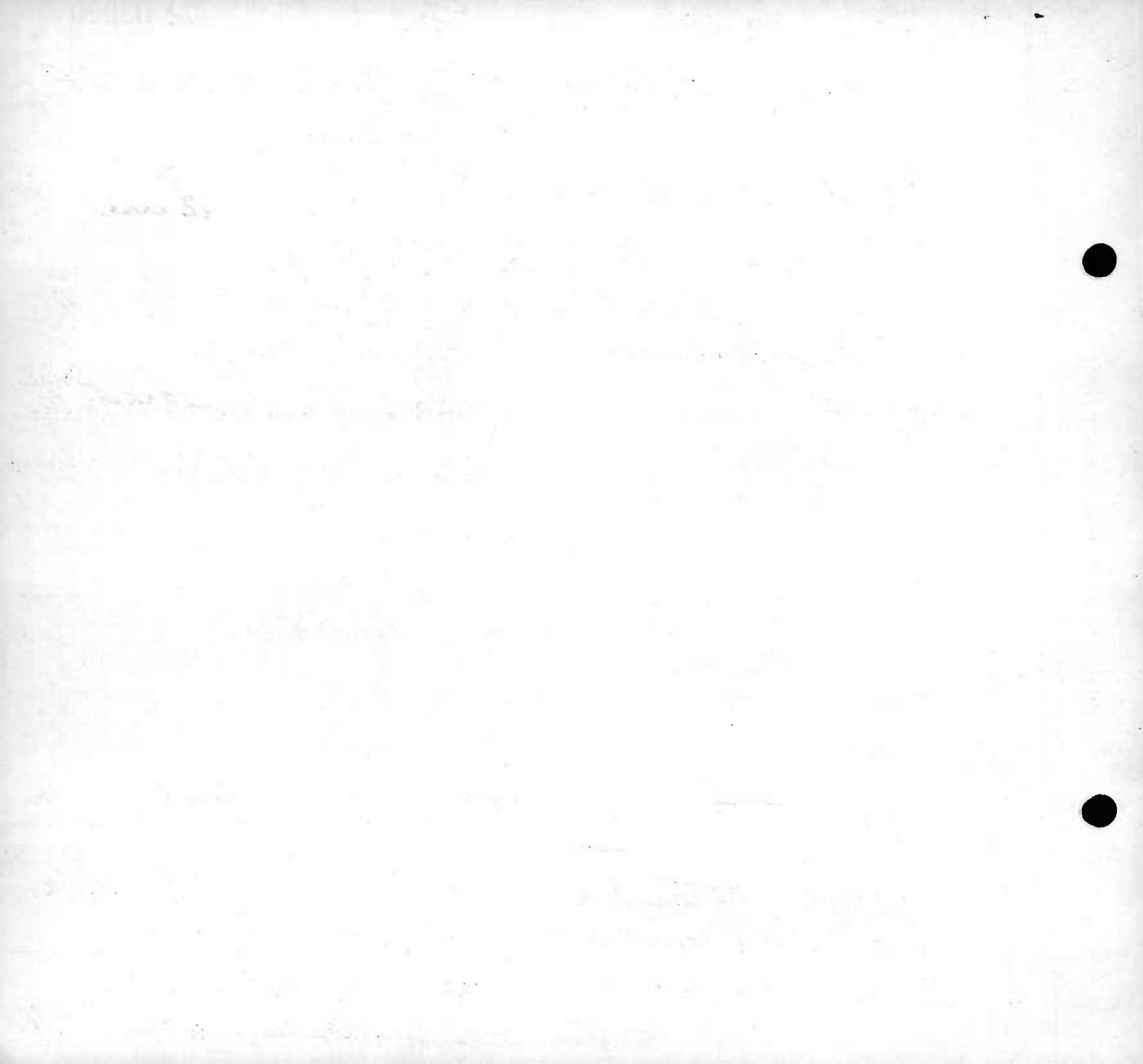
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>72 03979</u>	
<div style="display: flex; justify-content: space-between;"> BIRTH NO. <u>R-150</u> 72 03979 </div>					
1. NAME OF DECEASED (Type or Print) <u>ELLA RUBIN</u>			2. DATE AND HOUR OF DEATH <u>April 22, 1972</u> <u>125 P.</u> M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <div style="display: flex;"> <div style="flex: 1;"> FULL NAME OF HOSPITAL OR INSTITUTION <u>42 Sinai Hosp.</u> </div> <div style="flex: 1;"> (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) </div> </div>			4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) <div style="display: flex;"> <div style="flex: 1;"> A. STATE <u>Maryland</u> </div> <div style="flex: 1;"> B. COUNTY <u>2788</u> </div> </div>		
C. CITY OR TOWN <u>Baltimore</u>			D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
E. STREET AND NUMBER <u>5311 Nelson Avenue</u>					
5. SEX <u>Female</u>	6. RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 15, 1884</u>	9. AGE (In years last birthday) <u>87</u>	If Under 1 Yr. Months: _____ Days: _____ If Under 24 Hrs. Hours: _____ Min: _____
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>		11. BIRTHPLACE (State or foreign country) <u>Latvia</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>					
13. FATHER'S NAME <u>Rzy Hirsh</u>			14. MOTHER'S MAIDEN NAME <u>Hannah ?</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Mr. Howard Rubin</u>	
				ADDRESS <u>4315 Labyrinth Road 21215</u>	
18. CAUSE OF DEATH <div style="display: flex;"> <div style="flex: 1;"> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. </div> <div style="flex: 1;"> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Gran negative septicaemia</u> (B) CHRONIC DISEASE DUE TO, OR AS A CONSEQUENCE OF: <u>Chronic biliary tract disease</u> (C) </div> <div style="flex: 0.5;"> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>4 Hours</u> <u>2 days</u> </div> </div>					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>April 19 72 to April 22 19 72</u> that (I) (we) last saw the deceased alive on <u>April 22 19 72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Seymour H. Rubin</u>			23B. DATE SIGNED <u>4/22/72</u>		Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>
23C. PHYSICIAN'S NAME (Type) <u>Seymour H. RUBIN</u>			23D. ADDRESS <u>5415 Park Heights Ave</u>		
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>4/23/72</u>		24C. NAME OF CEMETERY or CREMATORY <u>Anshe Nesina</u>	
				24D. LOCATION (City, town, or county) (State) <u>Rosedale</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>APR 26 1972</u>		25B. NAME OF REGISTRAR <u>Robert E. Valley, M.D.</u>		25C. FUNERAL DIRECTOR <u>Sol Levinson & Bros. 6010 Reisterstown Rd.</u>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

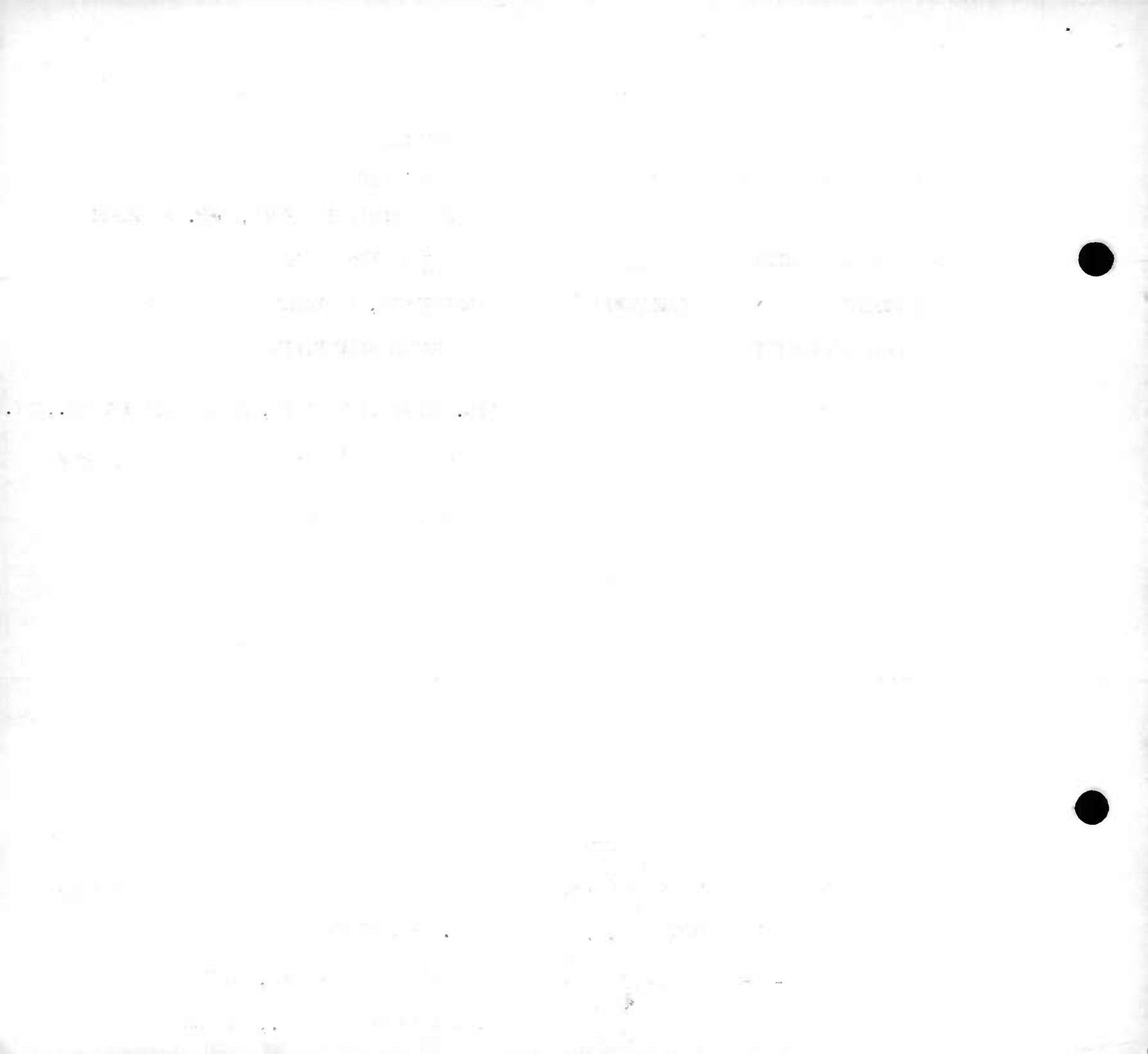
G-565 72 03980		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 03980	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) GERALD H. GAMERMAN		2. DATE AND HOUR OF DEATH APRIL 21/72 6:15 P.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY BALTO		C. CITY OR TOWN Baltimore	
FULL NAME OF HOSPITAL OR INSTITUTION 44 Union Memorial Hospital		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX Male		6. RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	
8. DATE OF BIRTH 2/17/1924		9. AGE (In years lost birthday) 48		If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mfg.		10B. KIND OF BUSINESS OR INDUSTRY Silver Cleaner		11. BIRTHPLACE (State or foreign country) Baltimore Md	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Harry Gamerman		14. MOTHER'S MAIDEN NAME Rebecca Libruvitz	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Army WWII		16. SOCIAL SECURITY NO.		17. INFORMANT Hillard Gamerman ADDRESS Drive 6825 Pinlicks	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) 410.9 + 250.9		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Acute Myocardial Infarct		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 23 min	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) Arteriosclerotic Ht Dis DUE TO, OR AS A CONSEQUENCE OF:		(C) _____	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		Dietary Mullins, Mild			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 1962 to April 19 72 , that (I) was lost saw the deceased alive on April , 19 72 and that in (my) own opinion death occurred on the date and hour and from the causes stated above. (I) was not (did not) view the body after death.					
23A. SIGNATURE Herbert Goldstone M.D.		23B. DATE SIGNED Apr. 22/72.		23C. PHYSICIAN'S NAME (Type) HERBERT GOLDSTONE	
23D. ADDRESS 3657 Clingdale Ave.		24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4/23/72	
24C. NAME OF CEMETERY OR CREMATORY Beth Jacob		24D. LOCATION (City, town, or county) (State) Starkenburg, Md.		25A. DATE REC'D BY HEALTH DEPT. APR 26 1972	
25B. NAME OF REGISTRAR John E. Jones, M.D.		25C. FUNERAL DIRECTOR Abel Union Bros.		ADDRESS 6010 Trust Rd.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-652		72 03981		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 03981	
BIRTH NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <u>Mildred Brewster</u>				2. DATE AND HOUR OF DEATH <u>4/20/72</u> <u>1 8:35 P.M.</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <u>House in the Pines Belvedere</u> <u>90</u>				A. STATE <u>MARYLAND</u>			
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				C. CITY OR TOWN <u>BALTIMORE</u>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <u>3901 FORDLEIGH ROAD, APT. A #21215</u>			
5. SEX <u>Female</u>	6. RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>12/18/26</u>		9. AGE (In years last birthday) <u>45</u>	10. If Under 1 Yr. Months Days	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>WAITRESS</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>CAFETERIA</u>		11. BIRTHPLACE (State or foreign country) <u>BALTIMORE, MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>MORRIS BROWNSTEIN</u>				14. MOTHER'S MAIDEN NAME <u>SARAH BROWNSTEIN</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>MRS. SARAH BROWNSTEIN, 3901 FORDLEIGH RD., APT. A</u>			
18. <u>1977</u> I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>Carc Carcinoma liver, metastatic</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause [A] stating the UNDERLYING CONDITION last. <u>Primary origin unknown</u>				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Primary origin unknown</u> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>6 months</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION <u>none</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>19</u> to <u>19</u> that (I) (we) last saw the deceased alive on <u>19</u> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>Conrad Acton</u>				23B. DATE SIGNED <u>21 APRIL 1972</u>		23C. PHYSICIAN'S NAME (Type) <u>CONRAD ACTON M.D.</u>	
23D. ADDRESS <u>2 E. READ STREET</u>		24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>					
24B. DATE <u>4-23-72</u>		24C. NAME OF CEMETERY OR CREMATORY <u>TIFERETH ISRAEL ANSHE SFARD</u>		24D. LOCATION (City, town, or county) (State) <u>ROSEDALE, MARYLAND</u>			
25A. DATE REC'D BY HEALTH DEPT. <u>APR 26 1972</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor, M.D.</u>		25C. FUNERAL DIRECTOR <u>SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD</u>			



FUNERAL DIRECTOR: IMPORTANT

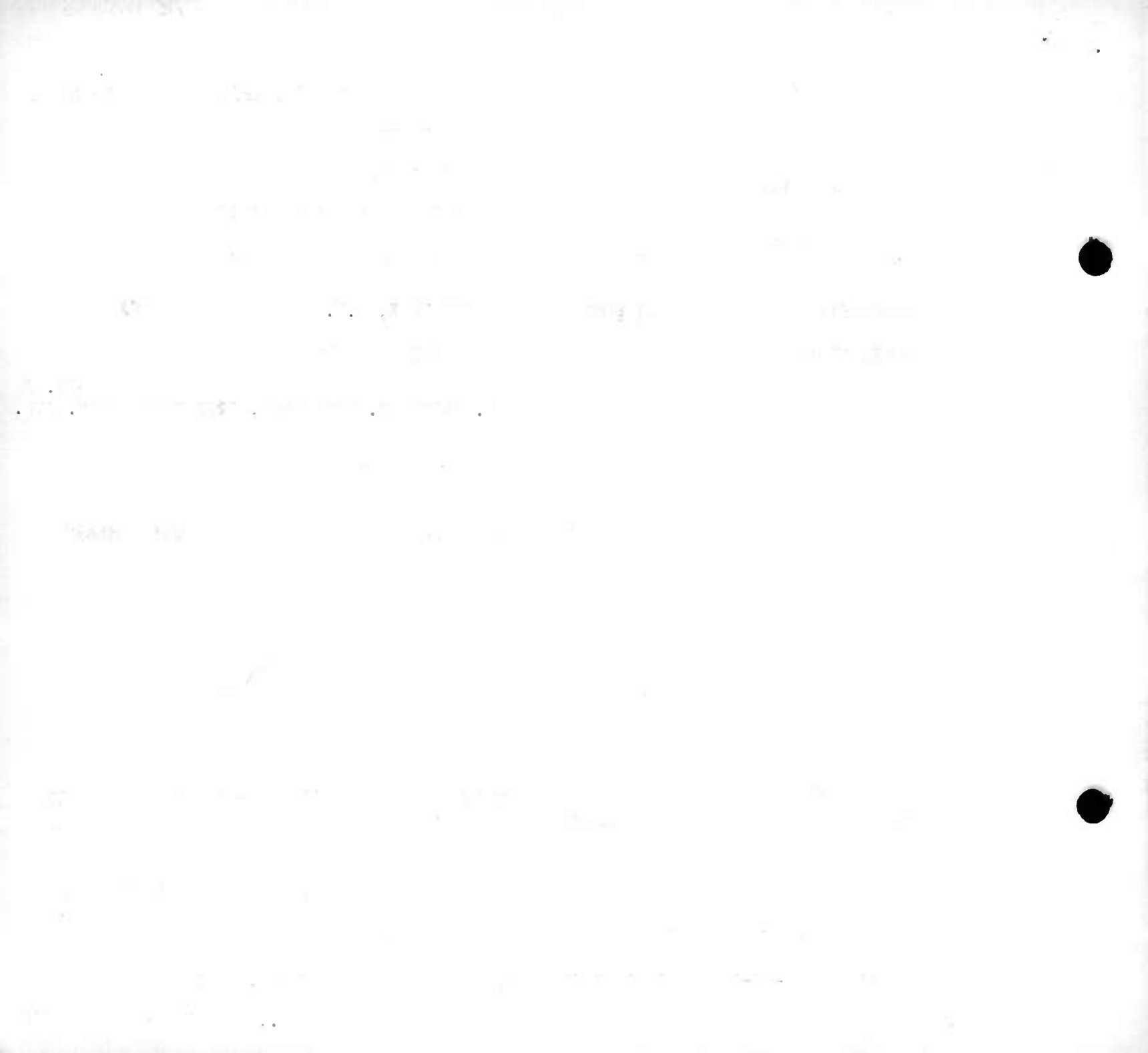
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

H-324 72-03982		BALTIMORE CITY HEALTH DEPARTMENT		72 03982	
BIRTH NO.		CERTIFICATE OF DEATH		REG. NO.	
1. NAME OF DECEASED (Type or Print) <u>Mutzler, Theresa S.</u>			2. DATE AND HOUR OF DEATH <u>4/20/72 745 PM</u>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <u>Sinai hospital of Baltimore Belvedere Ave at Greenspring Baltimore Md. 21215</u>			A. STATE <u>Maryland</u> B. COUNTY <u>2730</u>		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER <u>6701 Park Hgts Ave 21215</u>		
5. SEX <u>FEMALE</u>	6. RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6/16/92</u>	9. AGE (in years lost birthday) <u>59</u>	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>AT HOME</u>		11. BIRTHPLACE (State or foreign country) <u>BALTIMORE, MARYLAND</u>	
13. FATHER'S NAME <u>MOSES STRAUSS</u>		14. MOTHER'S MAIDEN NAME <u>CAROLINE ?</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <u>Pulmonary Embolism</u> <u>Deep Vein Thrombosis</u> <u>Fracture of neck of (R) Femur</u>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>15 hours</u>		
19. CAUSE OF DEATH <u>As CVD</u>					
20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>None</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) <u>Home</u>		21C. WHERE DID INJURY OCCUR? <u>6701 Park Hgts Ave 21215 Baltimore Md.</u>	
21D. TIME OF INJURY (APPROX.) <u>4 20 1972 7:10 AM</u>	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? <u>Pt fell down at home.</u>		
22. I certify that (I) (this hospital) attended the deceased from <u>4/20</u> 19 <u>72</u> to <u>4/20/72</u> 19 <u>72</u> and that (I) (we) lost saw the deceased olive on <u>4/20</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>J. Kalisky</u>			23B. DATE SIGNED <u>4/20/72</u>		
23C. PHYSICIAN'S NAME (Type) <u>201 KALISKY M.D.</u>			23D. ADDRESS <u>5946 c Green Meadow Pkwy Baltimore 21209</u>		
24A. BURIAL CREMATION, REMOVAL (Specify) <u>REMAT-BURIAL</u>		24B. DATE <u>4-28-72</u>		24C. NAME OF CEMETERY or CREMATORY <u>XXARXXKLOUDEN PARK</u>	
24D. LOCATION (City, town, or county) (State) <u>BALTIMORE, MARYLAND</u>					
25A. DATE REC'D BY HEALTH DEPT. <u>APR 26 1972</u>		25B. NAME OF REGISTRAR <u>John E. [unclear]</u>		25C. FUNERAL DIRECTOR <u>SOL LEVINSON & BROS. INC., 6010 REISTERSTOWN</u>	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

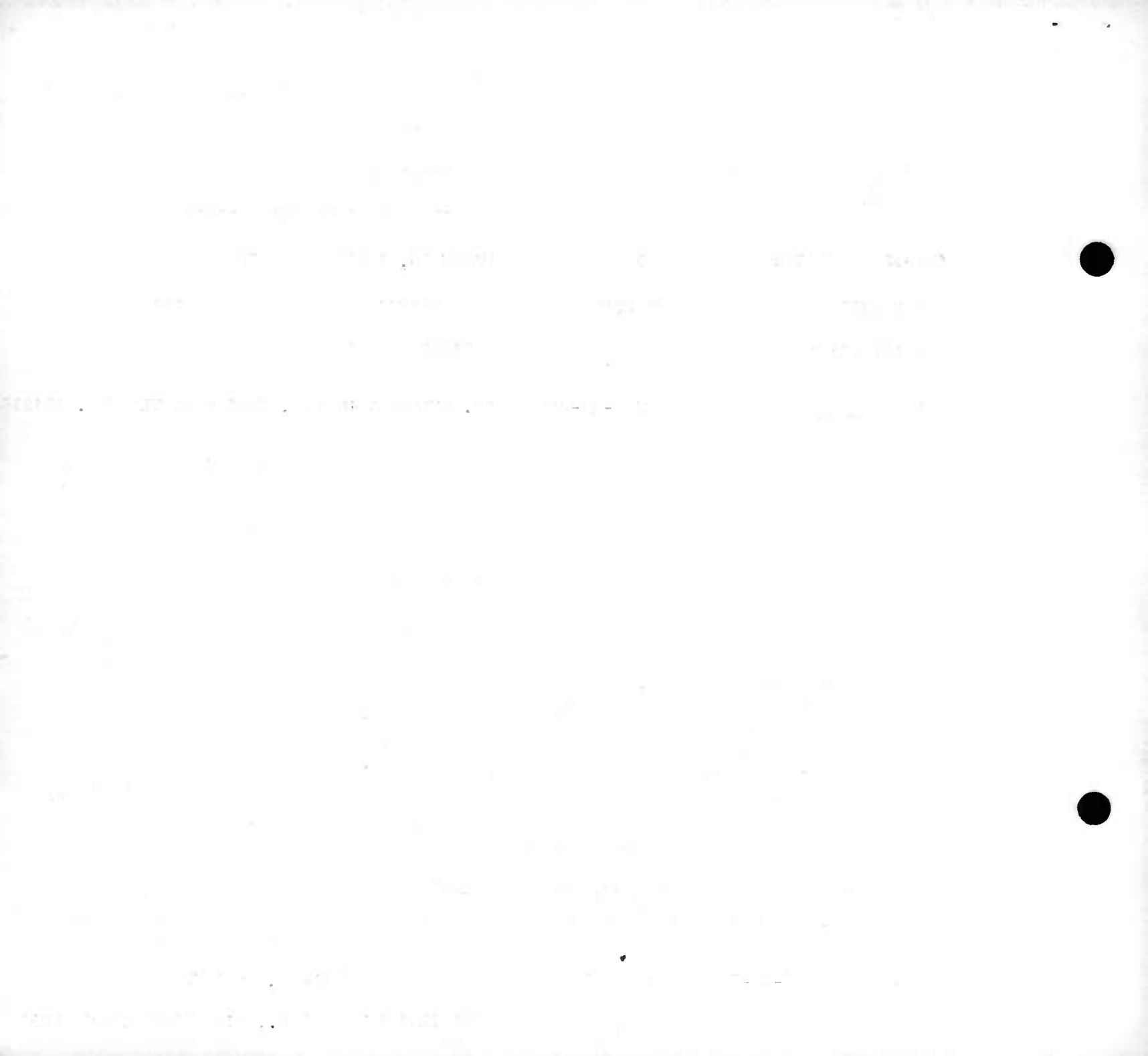
BALTIMORE CITY HEALTH DEPARTMENT 72 03983				72 03983		REG. NO.	
BIRTH NO. 1. NAME OF DECEASED (Type or Print) Pauline Greenhood				2. DATE AND HOUR OF DEATH April 23, 1972 10:30 A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 91 LEVINDALE				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY 2720			
				C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER 3935 CLARKS LANE #21215			
5. SEX Female		6. RACE WHITE Human		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7-10-1887	
				9. AGE (in years last birthday) 84		If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE				10B. KIND OF BUSINESS OR INDUSTRY AT HOME		11. BIRTHPLACE (State or foreign country) NEW YORK, N.Y.	
				12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME LOUIS SINGER				14. MOTHER'S MAIDEN NAME ROSE LEMBURG			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO.		17. INFORMANT MR. ALFRED A. GREENHOOD, 7233 PARK HIGHTS. AVE. APT. A			
18. CAUSE OF DEATH I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH DAYS (A) IMMEDIATE CAUSE PNEUMONIA DUE TO, OR AS A CONSEQUENCE OF: (B) ARTERIOSCLEROTIC CARDIO VASCULAR DISEASE YEARS DUE TO, OR AS A CONSEQUENCE OF: (C)			
19A. DATE OF OPERATION 0				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) yes	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (X) (this hospital) attended the deceased from May 16, 1969 to April 23, 1972 that (X) (we) last saw the deceased alive on April 23, 1972 and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (not) view the body after death.							
23A. SIGNATURE Soon Chul Hong, M.D.				23B. DATE SIGNED April 24, 1972		23C. PHYSICIAN'S NAME (Type) SOON CHUL HONG	
23D. ADDRESS LEVINDALE				24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL			
24B. DATE 4-24-72		24C. NAME OF CEMETERY OR CREMATORY HEBREW FRIENDSHIP		24D. LOCATION (City, town, or county) (State) BALTIMORE, MARYLAND			
25A. DATE REC'D BY HEALTH DEPT. ADD 26 1072		25B. NAME OF REGISTRAR John J. ...		25C. FUNERAL DIRECTOR SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

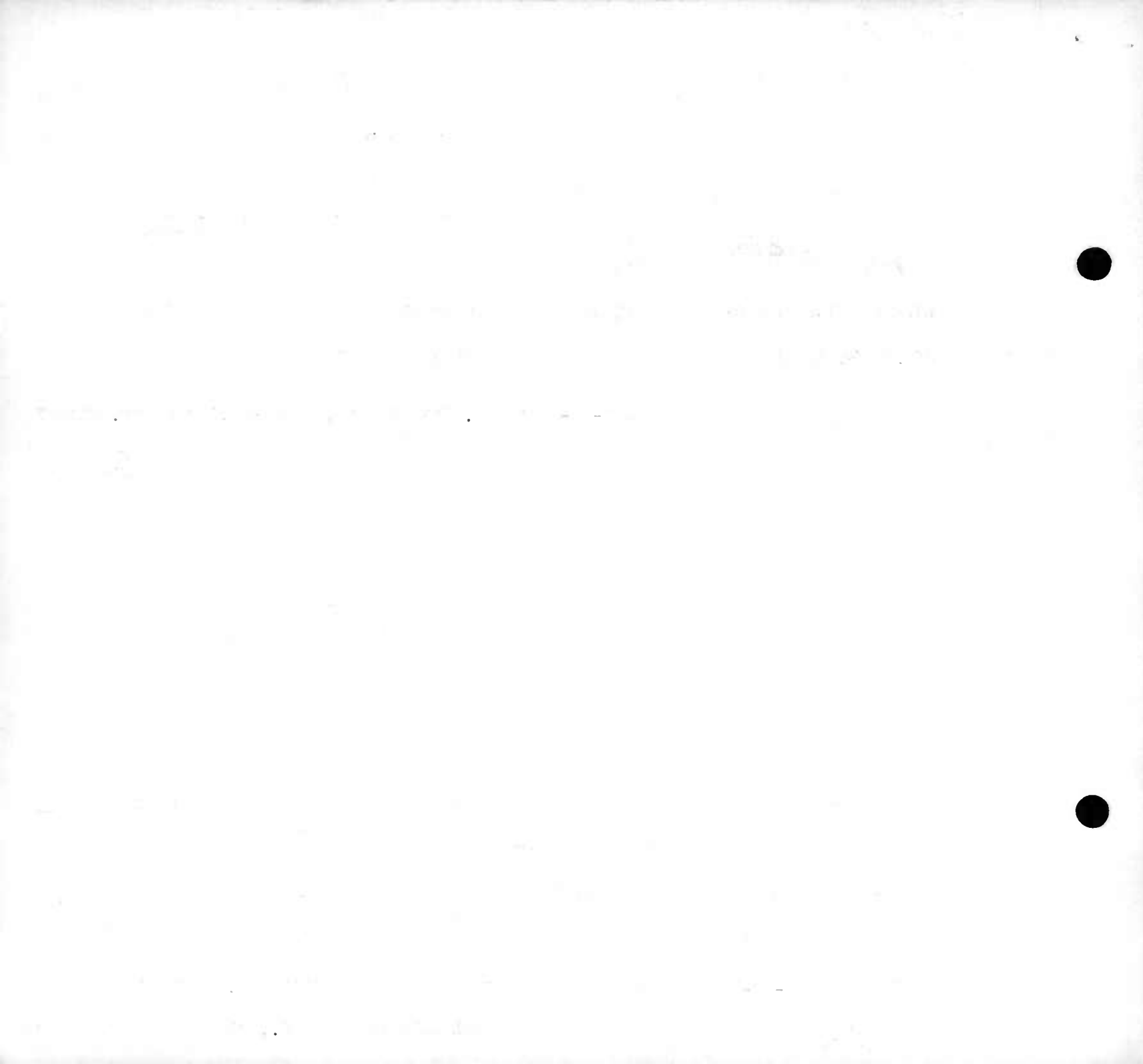
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>72 03984</u>	
T-512 72 03984				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <u>ROSE</u>		2. DATE AND HOUR OF DEATH <u>4/23/72</u> <u>2:25 P.M.</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>Sinai Hospital of Balto. Inc.</u> <u>42 Balto. Md.</u>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>2720</u> C. CITY OR TOWN <u>BALTIMORE</u> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>3720 CLARINTH ROAD #21215</u>	
5. SEX <u>FEMALE</u>	6. RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MARCH 25, 1893</u>	9. AGE (in years last birthday) <u>79</u>	10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>AT HOME</u>		11. BIRTHPLACE (State or foreign country) <u>RUSSIA</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>SAMUEL EXLER</u>			
14. MOTHER'S MAIDEN NAME <u>DIANE ?</u>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>			
16. SOCIAL SECURITY NO. <u>220-44-4308</u>		17. INFORMANT ADDRESS <u>DR. SYLVAN TOMPAKOV, 3901 GLENGYLE AVE. #21215</u>			
18. CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
(A) IMMEDIATE CAUSE <u>Cardio-respiratory Arrest</u> DUE TO, OR AS A CONSEQUENCE OF: <u>Anoxemia, Acidosis</u>				<u>Progressive one week.</u>	
(B) <u>Herniation of stomach & colon into thorax</u> DUE TO, OR AS A CONSEQUENCE OF: <u>undetermined</u>				<u>about 1 week?</u>	
(C) <u>Large hiatus hernia</u>				<u>many years</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>chronic pulmonary emphysema</u>				<u>Many years</u>	
19A. DATE OF OPERATION <u>4/22/72</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Tracheostomy for anoxemia & retained mucus</u>		20A. AUTOPSY? (Yes or No) <u>No</u>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input checked="" type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <input checked="" type="checkbox"/>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <input checked="" type="checkbox"/>	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) <input checked="" type="checkbox"/>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? <input checked="" type="checkbox"/>	
22. I certify that (I) (the hospital) attended the deceased from <u>about 1961</u> to <u>4/23/1972</u> that (I) (we) last saw the deceased alive on <u>4/22/1972</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Gerald N. Massid, M.D.</u>				23B. DATE SIGNED <u>4/23/72</u>	
23C. PHYSICIAN'S NAME (Type) <u>Gerald N. Massid, M.D.</u>		23D. ADDRESS <u>Pikesville Medical Center Pikesville, Md. 21208</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>4-24-72</u>		24C. NAME of CEMETERY or CREMATORY <u>OHEL YAKOV</u>	
24D. LOCATION (City, town, or county) (State) <u>BALTIMORE, MARYLAND</u>					
25A. DATE REC'D BY HEALTH DEPT. <u>APR 26 1972</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor</u>		25C. FUNERAL DIRECTOR ADDRESS <u>SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD</u>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

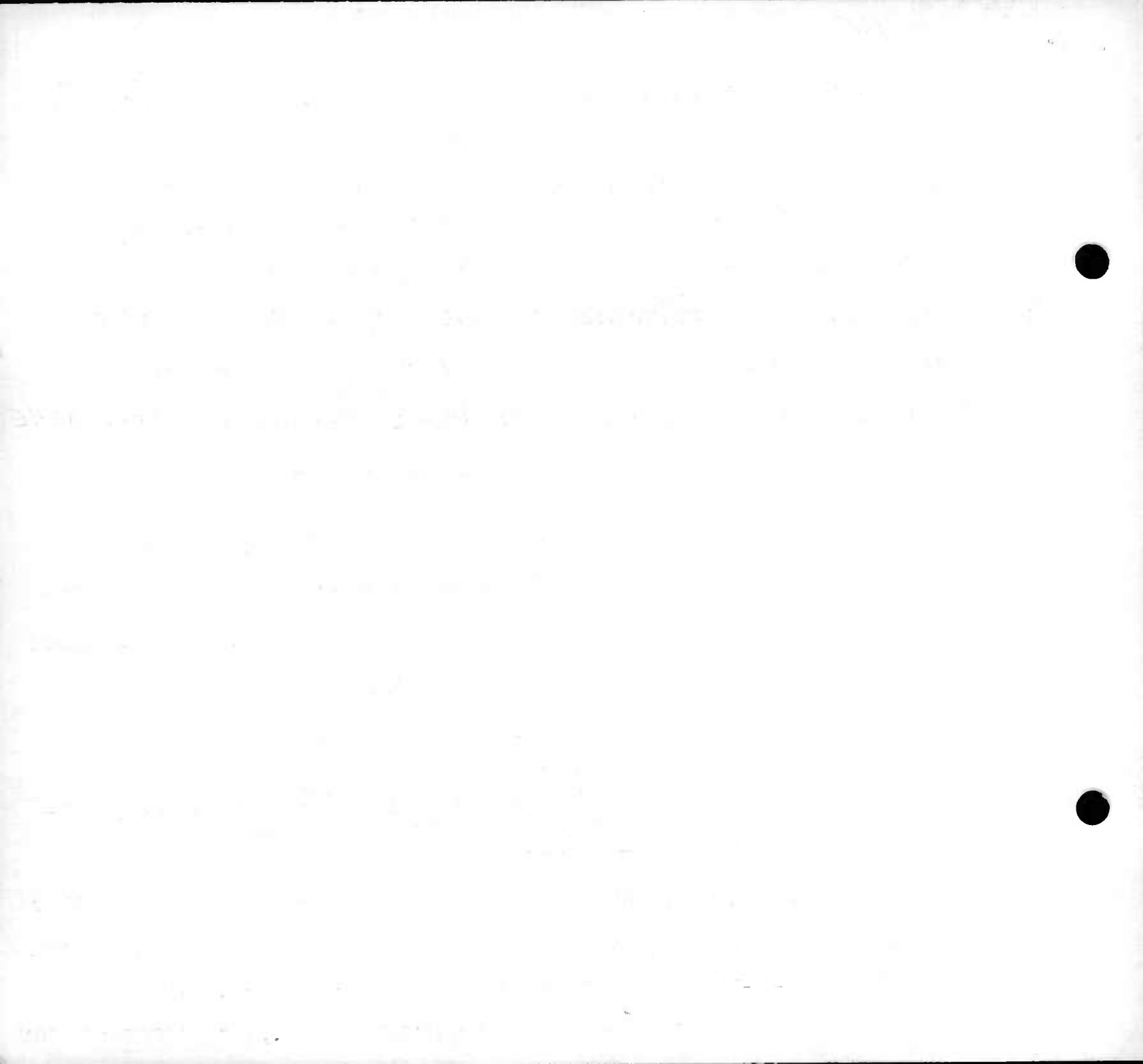
BALTIMORE CITY HEALTH DEPARTMENT			
BIRTH NO. 72 03985		CERTIFICATE OF DEATH 72 03985	
1. NAME OF DECEASED (Type or Print) Paula B Hill		2. DATE AND HOUR OF DEATH 4-23-72 11:55 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Sinai Hosp. of Baltimore		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY BALTO C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 7909 BROOKHAVEN ROAD #21207	
5. SEX FEMALE	6. RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5-28-97 9. AGE (In years lost birthday) 74 10. UNDER 1 Yr. Months: Days: 11. UNDER 24 Hrs. Hours: Mins.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SEWING MACHINE OPERATOR		10B. KIND OF BUSINESS OR INDUSTRY RETAIL	
11. BIRTHPLACE (State or foreign country) GERMANY		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME JOSEPH BERLINER		14. MOTHER'S MAIDEN NAME JULIA ?	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 521-18-9493	
17. INFORMANT MR. BURT STRAUS, 7909 BROOKHAVEN RD. #21207		ADDRESS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Cerebrovascular Accident		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 days	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). Arteriosclerotic Cardiovascular Dis.			
19A. DATE OF OPERATION 0	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No) No	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?	
22. I certify that (H) (this hospital) attended the deceased from 4-22 1972 to 4-23 1972 that (H) (we) last saw the deceased alive on 4-23 1972 and that (H) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (H) (We) (did) (did not) view the body after death.			
23A. SIGNATURE Joshua Frankel		23B. DATE SIGNED 4-23-72	
23C. PHYSICIAN'S NAME (Type) Joshua Frankel M.D.		23D. ADDRESS Sinai Hosp. of Balt	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL	24B. DATE 4-24-72	24C. NAME of CEMETERY or CREMATORY CHEVRA AHAVAS CHESD	24D. LOCATION (City, town, or county) (State) RANDALLSTOWN, MARYLAND
25A. DATE REC'D BY HEALTH DEPT. APR 26 1972	25B. NAME OF REGISTRAR John E. Kelly	25C. FUNERAL DIRECTOR SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD	



FUNERAL DIRECTOR: IMPORTANT

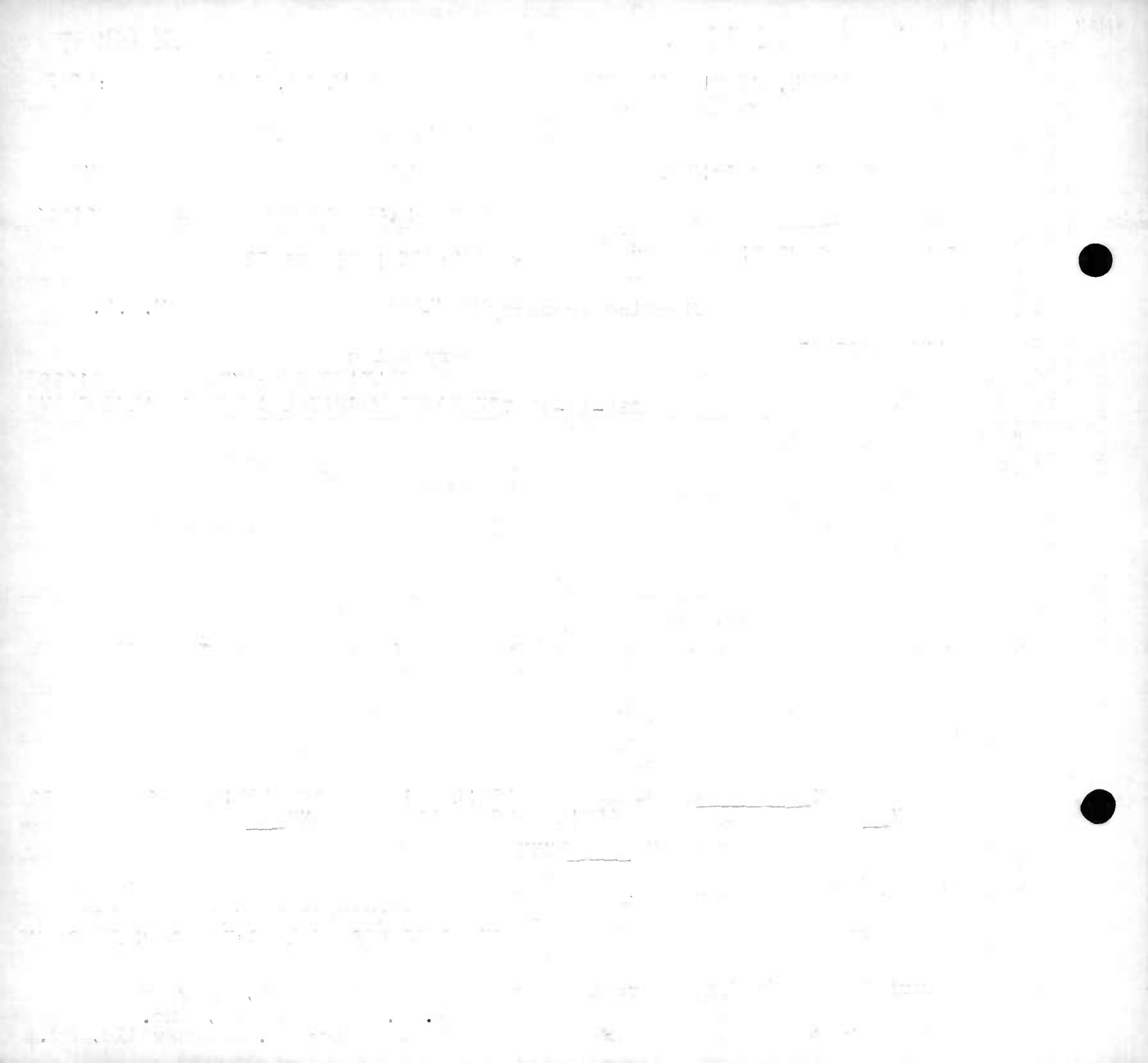
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. <u>72 03986</u>	
A-425 72 03986					
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>LOUIS ALEXANDER</u>		2. DATE AND HOUR OF DEATH <u>22 APR 72 19:00 A. M.</u>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <u>GOOD SAMARITAN HOSPITAL</u> <u>5601 LOCH RAVEN BLVD. BALTO., MD</u>		A. STATE & COUNTY <u>MD. BALTO.</u>		C. CITY OR TOWN <u>RANDALLSTOWN</u>	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		E. STREET AND NUMBER <u>3817 CHERRYBROOK RD.</u>	
5. SEX <u>MALE</u>	6. RACE <u>CAUCASIAN</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>SEPT. 15, 1912</u>	9. AGE (In years last birthday) <u>59</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>TEACHER</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>CITY SCHOOL</u>		11. BIRTHPLACE (State or foreign country) <u>NEW YORK, N.Y.</u>	
13. FATHER'S NAME <u>MORRIS ALEXANDER</u>		14. MOTHER'S MAIDEN NAME <u>MASOR, GOLDA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>133-03-7389</u>		17. INFORMANT <u>WIFE</u> <u>ANNE ALEXANDER</u>	
18. <u>250.91</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>CARDIAC ARREST</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>CHRONIC RENAL FAILURE</u> DUE TO, OR AS A CONSEQUENCE OF: (C) <u>DIABETES MELLITUS</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>5 MIN.</u> <u>1 YEAR</u> <u>30 YEARS</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		<u>ARTERIOSCLEROSIS, GENERALIZED</u>		<u>3.5 YEARS</u>	
19A. DATE OF OPERATION <u>NONE</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>NO</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <u>NO</u>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>N/A</u>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <u>N/A</u>	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) <u>N/A</u>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> <u>N/A</u>		21F. HOW DID INJURY OCCUR? <u>N/A</u>	
22. I certify that (I) (this hospital) attended the deceased from <u>MARCH 15</u> 19 <u>72</u> to <u>APRIL 22</u> , 19 <u>72</u> and that (I) (we) lost the deceased alive on <u>APRIL 22</u> , 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE <u>William D. Hillis, M.D.</u>		23B. DATE SIGNED <u>22 April 1972</u>		23C. PHYSICIAN'S NAME (Type) <u>William D. Hillis, M.D.</u>	
23D. ADDRESS <u>GOOD SAMARITAN HOSP. BALTO., MD.</u>		23E. NAME OF REGISTRAR <u>Robert E. Hillis</u>		23F. FUNERAL DIRECTOR <u>SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>4-24-72</u>		24C. NAME OF CEMETERY OR CREMATORY <u>BETH EL MEMORIAL PARK</u>	
24D. LOCATION <u>RANDALLSTOWN, MARYLAND</u>		24E. DATE REC'D BY HEALTH DEPT. <u>APR 26 1972</u>		24F. NAME OF REGISTRAR <u>Robert E. Hillis</u>	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

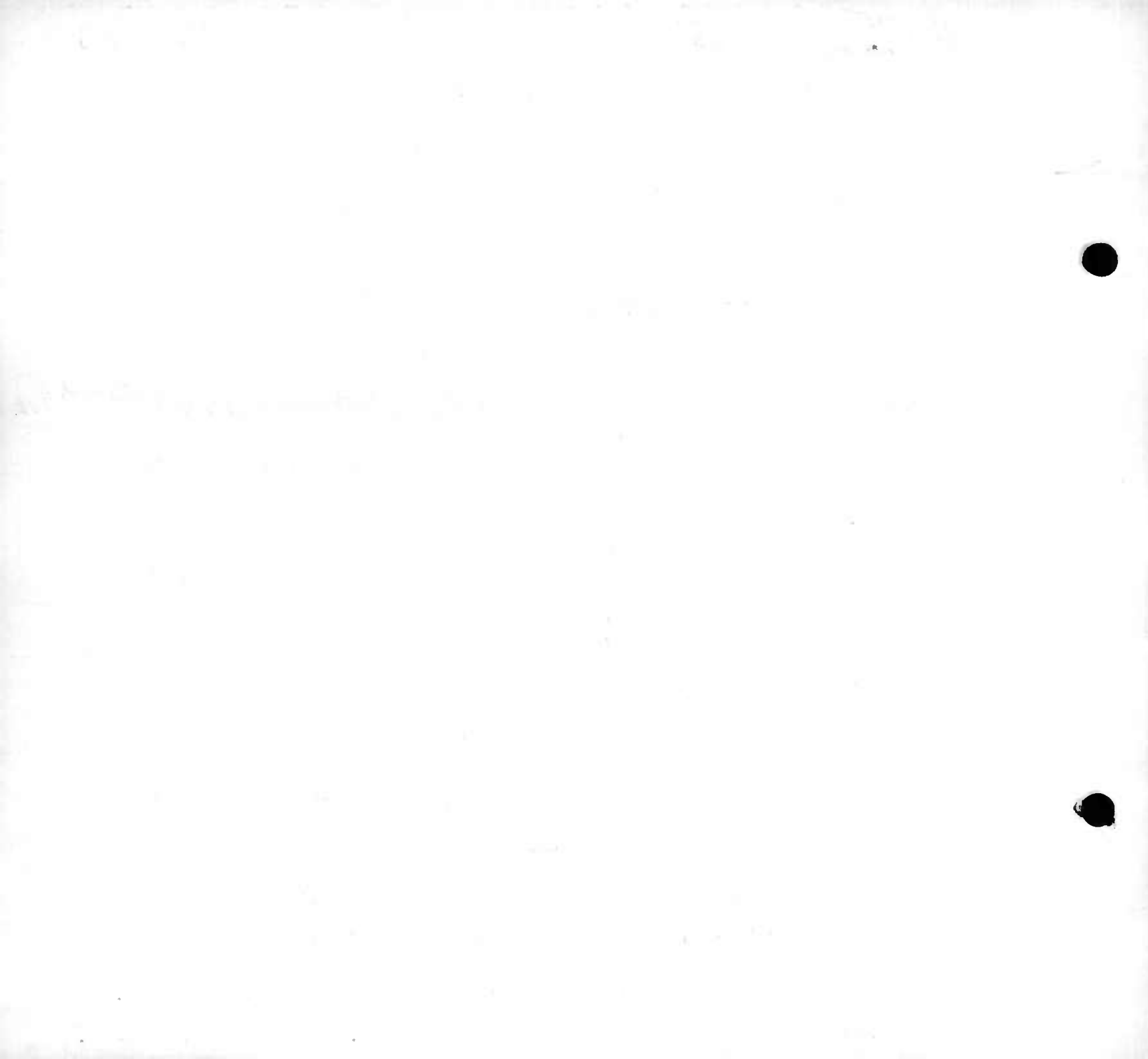
BIRTH NO. 8-400		BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		REG. NO. 72 03987	
1. NAME OF DECEASED (Type or Print) BIEHL, JENNIE JEANETTE				2. DATE AND HOUR OF DEATH APRIL 20, 1972 8:20 P M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) ST AGNES HOSPITAL				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE			
5. SEX FEMALE				6. RACE CAUCASIAN		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
				Clothing Industry		MARYLAND	
13. FATHER'S NAME JOHN LEFFERT				14. MOTHER'S MAIDEN NAME Mary Seipp			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO				16. SOCIAL SECURITY NO. 219-18-4057		17. INFORMANT BALTIMORE MARYLAND ADDRESS 21229 ST AGNES HOSPITAL CATON & WILKENS AVE	
18. 410.0 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) IMMEDIATE CAUSE Cardiac arrest DUE TO, OR AS A CONSEQUENCE OF:			
				(B) Acute myocardial infarction DUE TO, OR AS A CONSEQUENCE OF:			
				(C) Arteriosclerotic Cardiovascular disease. Hypertension			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
0				NO			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (X) (this hospital) attended the deceased from APRIL 19 19 72 to APRIL 20 19 72 that (X) (we) last saw the deceased alive on APRIL 20 19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (view) (view) the body after death.							
23A. SIGNATURE Eitatsu Henzan M.D.						23B. DATE SIGNED 4/20/72	
23C. PHYSICIAN'S NAME (Type) EITATSU HENZAN M.D.						23D. ADDRESS BALTIMORE MARYLAND 21229 ST AGNES HOSPITAL CATON & WILKENS AVE	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial		4/24/72		Lorraine Park		Woodlawn, Maryland	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS			
APR 26 1972		Edw. S. MacNabb Sons, Inc.		301 Frederick Rd. Catonsville, Md.			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

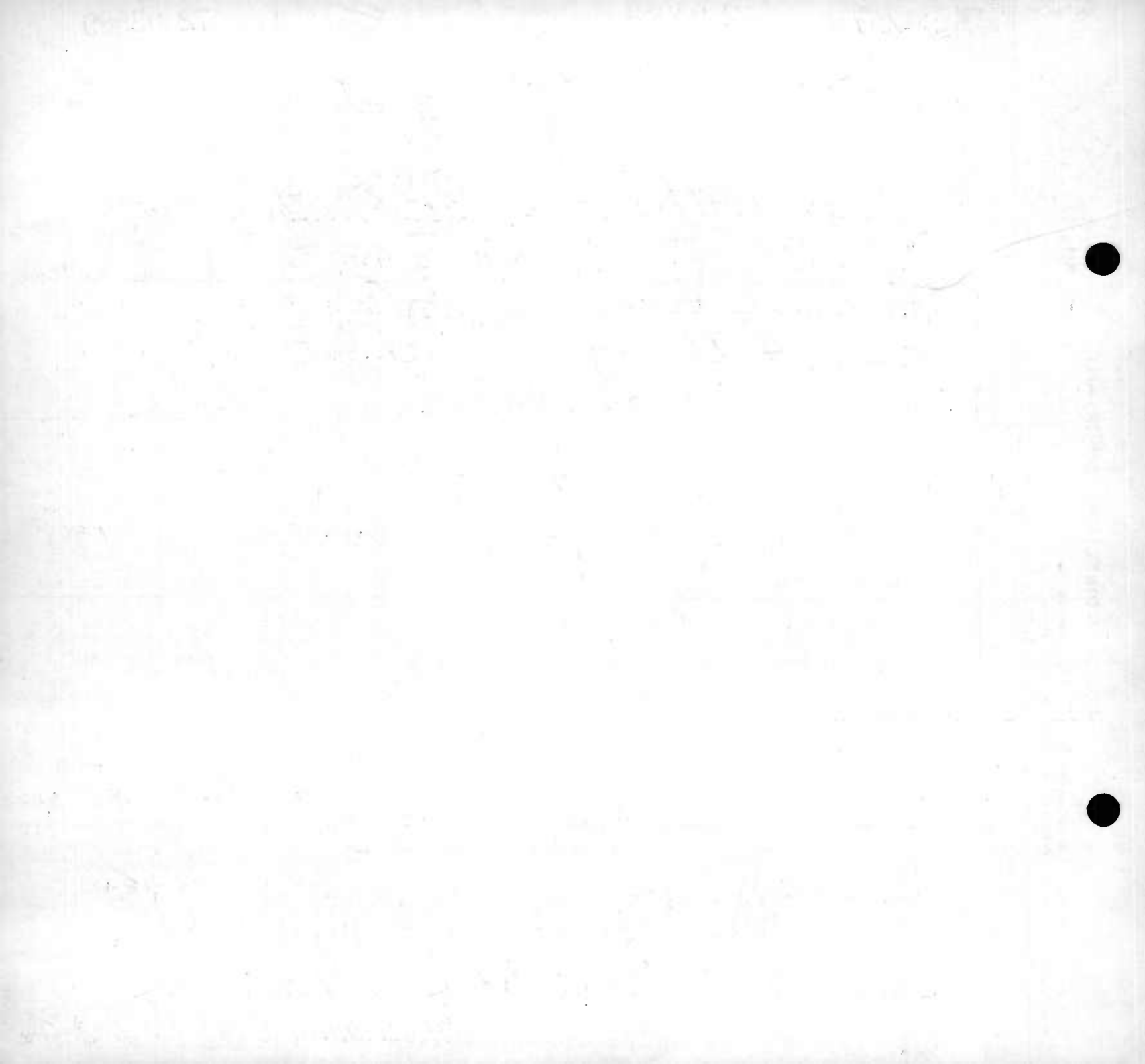
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 03985	
CERTIFICATE OF DEATH					
BIRTH NO. [REDACTED]		1. NAME OF DECEASED (Type or Print) <u>ATKINSON, P. Sharleen</u>		2. DATE AND HOUR OF DEATH <u>4/24/72</u> <u>1:25</u> <u>PM</u>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>1306</u>		
FULL NAME OF HOSPITAL OR INSTITUTION <u>Johns Hopkins Hospital</u>			C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			E. STREET AND NUMBER <u>3528 ROLAND AVE.</u>		
5. SEX <u>Female</u>	6. RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>09-05-28</u>	9. AGE (in years last birthday) <u>43</u>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>
11. BIRTHPLACE (State or foreign country) <u>Md.</u>			12. CITIZEN OF WHAT COUNTRY?		
13. FATHER'S NAME <u>George Orndoss</u>			14. MOTHER'S MAIDEN NAME <u>Mae Russell</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO.	17. INFORMANT <u>William Atkinson</u> ADDRESS <u>3528 Roland Ave.</u>		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>180X I</u>			CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>INTESTINAL OBSTRUCTION</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>METASTATIC CARCINOMA</u> DUE TO, OR AS A CONSEQUENCE OF: (C) <u>CARCINOMA OF THE UTERINE CERVIX</u>		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>II</u>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>7 WEEKS</u> <u>6 MONTHS</u> <u>2 YEARS</u>		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION <u>12/28/72</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>BOWEL OBSTRUCTION</u>		20A. AUTOPSY? (Yes or No) <u>NO</u>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>4/1</u> 19 <u>72</u> to <u>4/24</u> 19 <u>72</u> that (I) (we) last saw the deceased alive on <u>4/24</u> 19 <u>72</u> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.					
23A. SIGNATURE <u>Edward Goldbergh, MD.</u>			23B. DATE SIGNED <u>4/24/72</u>		23C. PHYSICIAN'S NAME (Type) <u>Edward Goldbergh, MD.</u>
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>			24B. DATE <u>4/27/72</u>		
24C. NAME of CEMETERY or CREMATORY <u>Mt. Olivet Cemetery</u>			24D. LOCATION (City, town, or county) (State) <u>Baltimore, City, Md.</u>		
25A. DATE REC'D BY HEALTH DEPT. <u>APR 26 1972</u>			25B. NAME OF REGISTRAR <u>Robert E. Seitz, Jr.</u>		
25C. FUNERAL DIRECTOR <u>Frank W. Seitz</u>			ADDRESS <u>814 W. 36th St.</u>		



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

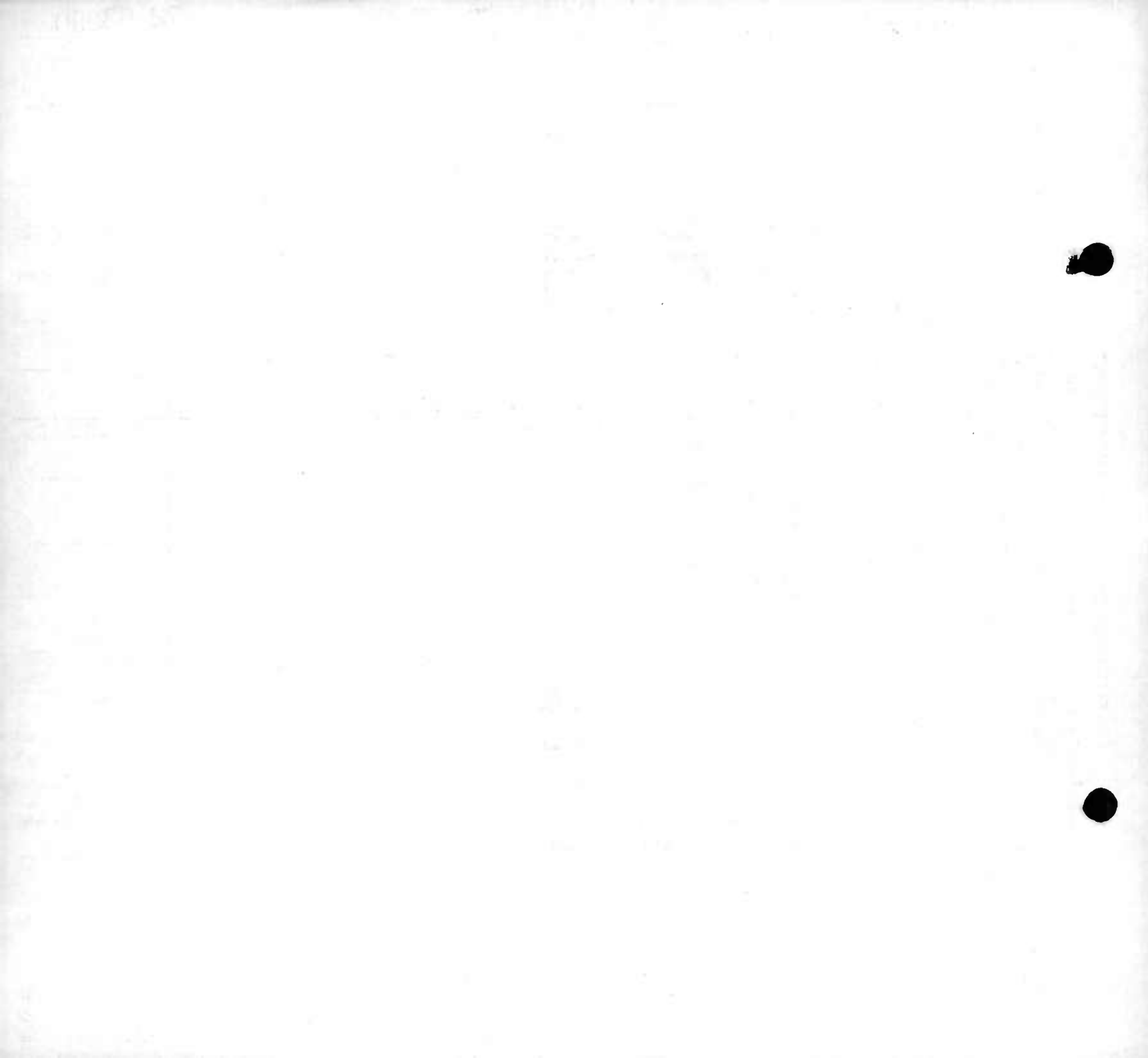
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>72 03989</u>	
<div style="display: flex; justify-content: space-between;"> D-100 72 03989 CERTIFICATE OF DEATH </div>					
<div style="display: flex; justify-content: space-between;"> <div> BIRTH NO. 1. NAME OF DECEASED (Type or Print) <u>Stuart Irwin Dayhoff</u> </div> <div> 2. DATE AND HOUR OF DEATH <u>4-18-72</u> <u>2 A.</u> M. </div> </div>					
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>3024 Northern Plw</u>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Md</u> B. COUNTY <u>2735</u> C. CITY OR TOWN <u>Balto</u> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>3024 Northern Plw</u>		
5. SEX <u>M</u>	6. RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>Nov 2, 1922</u>	9. AGE (In years last birthday) <u>49</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Salesman</u>			10B. KIND OF BUSINESS OR INDUSTRY <u>Johnnie's Used Car</u>		11. BIRTHPLACE (State or foreign country) <u>Balto</u>
13. FATHER'S NAME <u>James H. Dayhoff</u>			14. MOTHER'S MAIDEN NAME <u>Bulah Hahn</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>WW 2</u>			16. SOCIAL SECURITY NO. <u>214-76-9241</u>		17. INFORMANT <u>Mother</u>
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>Coronary insufficiency</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>Diabetes mellitus</u> DUE TO, OR AS A CONSEQUENCE OF: (C) _____		
19A. DATE OF OPERATION <u>0</u>			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from <u>Jan 30 1971</u> to <u>April 18 1972</u>, that (I) (we) last saw the deceased alive on <u>April 13 1972</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE <u>R Donald Jandorf</u>				23B. DATE SIGNED <u>4-18-72</u>	
23C. PHYSICIAN'S NAME (Type) <u>R Donald Jandorf</u>				23D. ADDRESS <u>7403 Harford Rd.</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>4/1/72</u>	24C. NAME OF CEMETERY or CREMATORY <u>Truist Lodge</u>		24D. LOCATION (City, town, or county) (State) <u>Balto Md</u>
25A. DATE REC'D BY HEALTH DEPT. <u>APR 26 1972</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor, M.D.</u>		25C. FUNERAL DIRECTOR ADDRESS <u>Ph Deenham 6067 Harford Rd</u>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		72 03990		72 03990	
BIRTH NO. <u>W-420</u>		72 03990		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <u>CHARLES WILLIS</u>		2. DATE AND HOUR OF DEATH <u>April 21 1972 12:50p M.</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <u>44 UNION MEMORIAL HOSPITAL</u> (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		4. USUAL RESIDENCE (When deceased lived, if institution; residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>903</u>			
5. SEX <u>M</u>		6. RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <u>04-09-1923</u>		9. AGE (In years last birthday) <u>49</u>		10. Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Central Supply</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Union Mem.</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>CHARLES WILLIS</u>		14. MOTHER'S MAIDEN NAME <u>BERTA PALMER</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>—</u>		16. SOCIAL SECURITY NO. <u>219-18-9094</u>		17. INFORMANT <u>MOTHER</u> ADDRESS <u>Bethesda, Md. SAME</u>	
18. <u>250.9 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>ACUTE PULMONARY EDEMA</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>CHRONIC RENAL FAILURE</u> DUE TO, OR AS A CONSEQUENCE OF: (C) <u>DIABETES MELLITUS</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Notify medical examiner)			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>04/20</u> 19 <u>72</u> to <u>04/21</u> 19 <u>72</u> that (I) (we) last saw the deceased alive on <u>04/21</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>[Signature]</u>		23B. DATE SIGNED <u>04/21/72</u>		23C. PHYSICIAN'S NAME (Type) <u>CESSOR VILLARON INTERN</u>	
23D. ADDRESS <u>3312 3rd LAWERT ST</u>		24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>			
24B. DATE <u>4/24/72</u>		24C. NAME OF CEMETERY or CREMATORY <u>PARKWOOD Cem.</u>		24D. LOCATION (City, town, or county) (State) <u>BALTO Co.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>APR 26 1972</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor, M.D.</u>		25C. FUNERAL DIRECTOR ADDRESS <u>PAHEEMANN 6067 HARFORD RD</u>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

7-000		72 03991		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 03991	
BIRTH NO.				1. NAME OF DECEASED (Type or Print) JAMES CALEB FEE			
2. DATE AND HOUR OF DEATH 4/25/72 12:00 A M.							
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) KEYCIRCLE HOSPICE 1214 BENTAW PLACE				4. USUAL RESIDENCE (Where deceased lived, If institution; residence before admission) A. STATE MARYLAND B. COUNTY 2748 C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 1105 BELVEDERE AVENUE			
5. SEX MALE		6. RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3-2-1896	
9. AGE (In years last birthday) 76		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired - Retail		10B. KIND OF BUSINESS OR INDUSTRY Bakery Products		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME WILLIAM H FEE		14. MOTHER'S MAIDEN NAME MARY E. SPENCER			
15. Was Deceased Ever In U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) UNKNOWN DOUBTFUL		16. SOCIAL SECURITY NO. 217-05-4050		17. INFORMANT: Atty- John H. Dumlér, Fidelity Bldg., City 1			
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ACUTE THROMBOSIS, cerebral (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: ARTERIOSCLEROTIC CVD (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____ ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 mo			
19A. DATE OF OPERATION 0 N/A		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (notify medical examiner) NO		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (the hospital) attended the deceased from 3-3-1972 to 4/24-1972 that (I) last saw the deceased alive on 4/24-1972 and that (in my) opinion death occurred on the date and hour and from the causes stated above. (I) (the) (did not) view the body after death.							
23A. SIGNATURE Matyas Relle M.D.				23B. DATE SIGNED 4/25/72		23C. PHYSICIAN'S NAME (Type) MATYAS RELLE, M.D.	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 4/25/72		24C. NAME OF CEMETERY or CREMATORY Woodlawn Cemetery		24D. LOCATION (City, town, or county) (State) Woodlawn, Balto. Co., Md.	
25A. DATE REC'D BY HEALTH DEPT. APR 26 1972		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS STEWART & MOWEN CO. 108 W. North Av. Cit.			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>72 03992</u>	
BIRTH NO. <u>T-465</u>		72 03992		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <u>Tillman - Leslie</u>		2. DATE AND HOUR OF DEATH <u>4-22-72</u> <u>1:10</u> <u>PM</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <u>UNION MEMORIAL HOSPITAL</u>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MD</u> B. COUNTY <u>ANNE ARUNDEL</u>			
FULL NAME OF HOSPITAL OR INSTITUTION <u>UNION MEMORIAL HOSPITAL</u>		C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <u>Male</u>		6. RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <u>07-19-98</u>		9. AGE (In years last birthday) <u>73</u>		10. AGE (In years last birthday) If Under 1 Yr. Months: Days: Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Rubber Industry</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland (Balto)</u>	
12. CITIZEN OF WHAT COUNTRY <u>American</u>		13. FATHER'S NAME <u>Adolph Tillman</u> <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown - Elizabeth Staylor</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> WWI		16. SOCIAL SECURITY NO. <u>212 254087</u>		17. INFORMANT <u>CHART</u>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>156.9 I</u> <u>Heart Throic Ca, from illness</u>		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Heart</u> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u>	
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>II</u>					
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>Yes</u>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>04-16</u> 19 <u>72</u> to <u>04-22</u> 19 <u>72</u> that (I) (we) last saw the deceased alive on _____ 19_____ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>[Signature]</u>		23B. DATE SIGNED <u>04-22-72</u>		23C. PHYSICIAN'S NAME (Type) <u>TULLIO BARTOLINI</u>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>4/25/72</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Druid Ridge Cemetery</u>	
24D. LOCATION <u>Pikesville, Balto. Co., Md.</u>		25A. DATE REC'D BY HEALTH DEPT. <u>APR 26 1972</u>		25B. NAME OF REGISTRAR <u>[Signature]</u>	
25C. FUNERAL DIRECTOR <u>STEWART & MOWEN CO.</u>		25D. ADDRESS <u>108 W. NORTH AVE (1)</u>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>72 03993</u>
BIRTH NO. <u>S-765</u>		72 03993		CERTIFICATE OF DEATH
1. NAME OF DECEASED (Type or Print) <u>Lizzie Springfield</u>		2. DATE AND HOUR OF DEATH <u>April 19, 1972</u> M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>90 Midtown Nursing Home</u>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>402</u> C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>770 W. Saratoga St. Apt. 403</u>		
5. SEX <u>Female</u>	6. RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6-2-1890</u>	9. AGE (In years last birthday) <u>81</u> If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Unemployed</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>North Carolina</u>
13. FATHER'S NAME <u>Saunders Graham</u>		14. MOTHER'S MAIDEN NAME <u>Martha</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Earl Scott 1211 Kitmore Rd. #12</u>
18. <u>412.4 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH <u>Cardio-Respiratory Failure</u> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Arteriosclerotic CVA's</u> (B) <u>Gen + Cerebral Arteriosclerosis</u> DUE TO, OR AS A CONSEQUENCE OF: (C) <u>Amputated @ dead -</u> II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <u>Hypothyroidism</u>		
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from <u>April 6, 1972</u> to <u>April 19, 1972</u> that (I) (we) last saw the deceased alive on <u>April 19, 1972</u> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.				
23A. SIGNATURE <u>William D. Roper</u>		23B. DATE SIGNED		23C. PHYSICIAN'S NAME (Type) <u>William D. Roper</u>
23D. ADDRESS <u>6615 Reisterstown Rd</u>		24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		
24B. DATE <u>4-22-72</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Mt. Auburn</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>
25A. DATE REC'D BY HEALTH DEPT. <u>APR 26 1972</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor, M.D.</u>		25C. FUNERAL DIRECTOR <u>Charles A. Rice</u> ADDRESS <u>661 W. BARRE ST.</u>



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Baltimore City Health Department				CERTIFICATE OF DEATH		REG. NO. 72 03994	
BIRTH NO. 1. NAME OF DECEASED (Type or Print) JONES, EVA L.				2. DATE AND HOUR OF DEATH 4-21-72 11:15 A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY 603			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 33 THE JOHNS HOPKINS HOSPITAL				C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER 2109 E. FAIRMOUNT AVE.			
5. SEX Female	6. RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-11-07	9. AGE (In years last birthday) 65	If Under 1 Yr. Months Days	If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME JOHN CRIPPER				14. MOTHER'S MAIDEN NAME NORA Fenwin			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO. 212-12-6153	17. INFORMANT ADDRESS Ogress Cropper 2109 E. Fairmount Ave.			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH Carcinoma involving Pancreas, Bile ducts, Stomach, Colon. (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) Myocardial Infarction, Pulm Embolus and CVA (C) Due to, or as a consequence of: He ruled out as immediate cause.				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION 4-17-72		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED OBSTRUCTIVE Jaundice, GIobst.		20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 4-4-1972 to 4-21-1972 that (I) (we) last saw the deceased alive on 4-21-1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Kenneth A. Krackow, M.D.				23B. DATE SIGNED 4-21-72		23C. PHYSICIAN'S NAME (Type) KENNETH A. KRACKOW, M.D.	
23D. ADDRESS THE JOHNS HOPKINS HOSPITAL							
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4-26-73		24C. NAME OF CEMETERY OR CREMATORY Mt. Auburn		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. APR 26 1972		25B. NAME OF REGISTRAR Robert E. Taylor, R.D.		25C. FUNERAL DIRECTOR Charles A. Rice 661 W. Barre St.			

• T •

author: date: 02/04/02

1. NAME OF DECEASED (Type or Print) Shelley Scriber		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/>		Month 4	Day 24	Year 72	Hour M.
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 38 University Hospital		3. DATE PRONOUNCED DEAD Month 4 Day 24 Year 72		Hour 9:35 p. M.			
6. SEX female		7. RACE Negro		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Balto.	
9. DATE OF BIRTH 6/23/64		10. AGE (In years last birthday) 7		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Herman Henson		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		15. MOTHER'S MAIDEN NAME Sylvia Scriber		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) NO	
17. SOCIAL SECURITY NO. NONE		18. INFORMANT Sylvia Scriber		ADDRESS 2005 W. MULBERRY ST.			
19. E814.71 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Multiple injuries (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) no			
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) STREET		22C. WHERE DID INJURY OCCUR? 300 blk. of North Pulaski Street			
22D. TIME OF INJURY (APPROX.) 4 24 72 7:35 p. m.		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? Subject pedestrian hit by car.			
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		Deputy CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Werner U. Spitz, M.D.		DATE SIGNED 4/25/72					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4/25/72		24C. NAME of CEMETERY or CREMATORY Arbutus Mem PK		24D. LOCATION (City, town, or county) (State) Arbutus Md	
25A. DATE REC'D BY HEALTH DEPT. APR 26 1972		25B. NAME OF REGISTRAR Robert E. Farber, M.D.		25C. FUNERAL DIRECTOR Charles A. Rice		ADDRESS 661 W. Barre St	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>72 03996</u>
4-220 72 03996		CERTIFICATE OF DEATH		
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>Mr. Louise Hughes</u>		2. DATE AND HOUR OF DEATH <u>4/20/72</u> <u>1830</u> <u>A. M.</u>
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>402</u>		
FULL NAME OF HOSPITAL OR INSTITUTION <u>University of Maryland</u>		C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		E. STREET AND NUMBER <u>505 W. Mulberry St</u>		
5. SEX <u>Female</u>	6. RACE <u>Black</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>1-13-12</u>	9. AGE (in years last birthday) <u>60</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>South Carolina</u>
13. FATHER'S NAME <u>Robert Doughty</u>		14. MOTHER'S MAIDEN NAME <u>Dina Gibson</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Isadora Mack</u>
18. <u>410.9 I</u>		CAUSE OF DEATH		ADDRESS <u>505 W. Mulberry St.</u>
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Shock, probably Cardiac</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>7 hours</u>
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) <u>Probable MI; Revascularized</u>		<u>7 hours</u>
		(C) <u>ASCVD, P.M.</u>		<u>Several years</u>
II		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <u>obesity</u>		<u>many years</u>
19A. DATE OF OPERATION <u>0</u>	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No) <u>NO</u>	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?		
22. I certify that <u>(X)</u> (this hospital) attended the deceased from <u>4/19</u> 19 <u>72</u> to <u>4/20</u> 19 <u>72</u> that <u>(X)</u> (we) last saw the deceased alive on <u>4/20</u> 19 <u>72</u> and that in <u>(we)</u> (our) opinion death occurred on the date and hour and from the causes stated above. <u>(X)</u> (We) (did) (did not) view the body after death.				
23A. SIGNATURE <u>Richard A. Tomasulo M.D.</u>		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>4/20/72</u>
23C. PHYSICIAN'S NAME (Type) <u>Richard A. Tomasulo M.D.</u>		23D. ADDRESS <u>Univ. of Md. Hosp.</u>		
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>	24B. DATE <u>4-25-72</u>	24C. NAME OF CEMETERY OR CREMATORY <u>Mt. Auburn</u>	24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>APR 26 1972</u>	25B. NAME OF REGISTRAR <u>Robert E. Farber, M.D.</u>	25C. FUNERAL DIRECTOR <u>Charles A. Rice</u> ADDRESS <u>661 W. Barre St.</u>		



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>72 03997</u>	
W-300 72 03997		CERTIFICATE OF DEATH			
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		GEORGE A. WHITE		APRIL 21, 1972 5 ⁰⁰ P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			A. STATE B. COUNTY		
SOUTH BALTIMORE GEN. HOSPITAL			Maryland		
			C. CITY OR TOWN		D. INSIDE CITY LIMITS?
			Baltimore		YES <input type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER		
			804 Leadenhall St.		
5. SEX	6. RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months Days
MALE	BLACK	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	4-17-29	43	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
				Virginia	
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
Luther White			Fannie H. Mosley		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS
No					Shirley White 804 Leadenhall St.
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)			CAUSE OF DEATH		
35X I			Bilateral Bronchopneumonia		
ANTECEDENT CAUSES			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			Meningitis, Pul. BACTERIAL		
			Pulmonary embolism & Sarcoidosis		
			(B) DUE TO, OR AS A CONSEQUENCE OF:		
			status Pepsic ulcer		
			(C) Polymyositis		
MEDICAL CERTIFICATION					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
2				Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
				Yes	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
(Month) (Day) (Year) (Hour)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from 4-17 1972 to 4-21 1972, that (I) (we) last saw the deceased alive on 4-21 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
Nelson R. DeLoach				4/21/72	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
NELSON R. DE LOACH				SOUTH BALT. GEN. HOSP.	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		4-27-72		Arbutus Mem. Park	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
APR 26 1972		Robert E. Fisher, Jr.		Charles A. Rice 661 W. Barre St.	

4/27/72 - Autopsy showed sarcoidosis
to be underlying cause of death -
Information from Dr. Nelson De Lara,
South Belto Gen Hosp. - 2nd phone
Palio during childhood - should be
in part II. ge

open 4/13/72 + 4/17/72
per M. B. H.
JH

75-00013

12-1-1943

1-10-43
 43
 Baltimore, Maryland
 W.E.A.
 Robert Smith
 1101 Calvert Ave. 21218
 Mrs. Gladys Smith
 1101 Calvert Ave. 21218
 212-22-7100
 212-22-7100

(Signature)
 (Signature)

WALTER D. BROWN

25X-100-001101

4-17-72

Arthur Memorial Park

Baltimore, Maryland

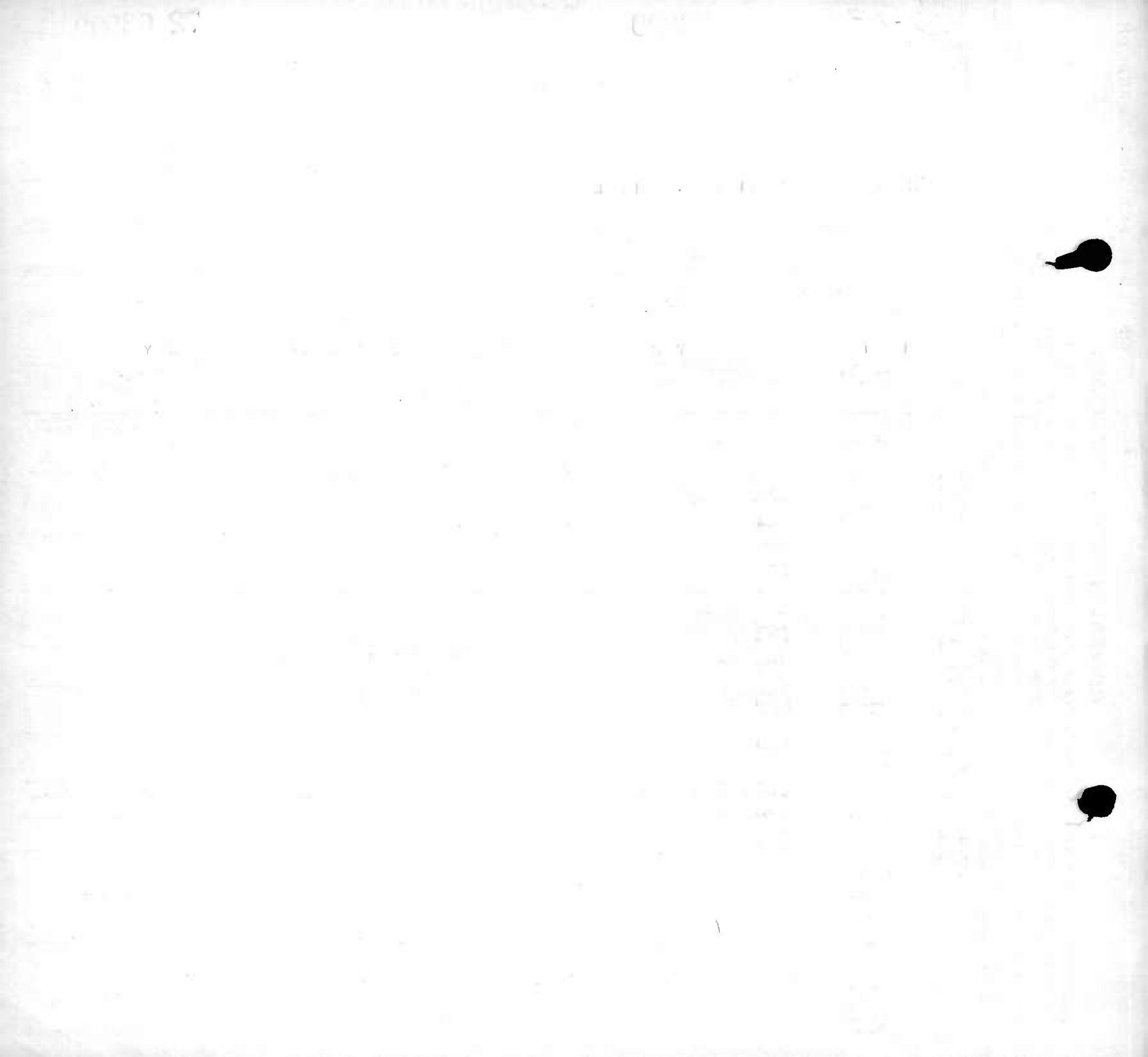
1101 Calvert Ave. 21218
 212-22-7100

NON MED PER DR. KORNBLUM

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-635 72 03999		BALTIMORE CITY HEALTH DEPARTMENT		X CERTIFICATE OF DEATH		72 03999	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>Burton, George</u>		2. DATE AND HOUR OF DEATH <u>4/19/72</u> <u>1 15</u> P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>ALLEGANY</u>		C. CITY OR TOWN <u>Cum berland</u>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
FULL NAME OF HOSPITAL OR INSTITUTION <u>THE JOHNS HOPKINS HOSPITAL</u>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		E. STREET AND NUMBER <u>4 PAGE COURT</u>			
5. SEX <u>M</u>	6. RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12/27/24</u>	9. AGE (in years last birthday) <u>52</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Exec.</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>KELLY SPRINGFIELD</u>		11. BIRTHPLACE (State or foreign country) <u>Alabama</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>WILLIAM EUGENE BURTON</u>		14. MOTHER'S MAIDEN NAME <u>LOUISE REBECCA MC ELDERRY</u>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>F. B. Cole 708 Cherokees St. BALTO MD</u>		18. <u>470.9</u> CAUSE OF DEATH		DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <u>Coronary Thrombosis</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 hour</u>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Anteriosclerotic Cardiovascular Dis.</u>		(B) DUE TO, OR AS A CONSEQUENCE OF: <u>UNKNOWN</u>		(C) _____	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>4/19</u> 19 <u>72</u> to <u>4/19</u> 19 <u>72</u> that (I) (we) last saw the deceased alive on <u>4/19</u> 19 <u>72</u> and that (a) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.		23A. SIGNATURE <u>Robert A. Vigersty, MD</u> DEGREE		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>4/19/72</u>	
23C. PHYSICIAN'S NAME (Type) <u>Robert A. Vigersty, MD</u> DEGREE		23D. ADDRESS <u>601 N. Broadway, Baltimore, Md.</u>		24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>4/22/72</u>	
24C. NAME OF CEMETERY OR CREMATORY <u>Oakhill Cemetery</u>		24D. LOCATION (City, town, or county) (State) <u>Talladega, Alabama</u>		25A. DATE REC'D BY HEALTH DEPT. <u>APR 26 1972</u>		25B. NAME OF REGISTRAR <u>Robert E. J. J. J.</u>	
25C. FUNERAL DIRECTOR <u>Robert E. J. J. J.</u>		ADDRESS <u>21223 Frederick Ave</u>		VS 150-REV. 1/1/68			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>72 04000</u>	
<div style="display: flex; justify-content: space-between;"> G-520 72 04000 CERTIFICATE OF DEATH </div>					
1. NAME OF DECEASED (Type or Print) <u>GOINES, ALICE</u>			2. DATE AND HOUR OF DEATH <u>4/24/72</u> <u>3:37</u> A.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <u>JOHNS HOPKINS HOSPITAL</u>			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>BALT.</u> B. COUNTY <u>CITY</u>		
FULL NAME OF HOSPITAL OR INSTITUTION <u>THE JOHNS HOPKINS HOSPITAL</u>			C. CITY OR TOWN <u>CITY</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>SEPA</u>			E. STREET AND NUMBER <u>1523 RIGGS AVE</u>		
5. SEX <u>F</u>	6. RACE <u>N</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>09-11-20</u>	9. AGE (in years last birthday) <u>51</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>S.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>GILMORE WILLIAM</u>			14. MOTHER'S MAIDEN NAME <u>FRANCES MCKUNE</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS <u>Samuel Goings 2320 Guilford</u>		
18. <u>446.01</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>Cardiopulmonary Arrest 3 hrs.</u> DUE TO, OR AS A CONSEQUENCE OF: <u>spontaneous Rupture of the Colon & Peritonitis</u> (B) DUE TO, OR AS A CONSEQUENCE OF: <u>Polyarteritis Nodosa</u> (C) <u>5 days</u> <u>6 mos.</u>		
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>YES</u>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSE OF DEATH? <u>NO</u>		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from <u>3/21</u> 19 <u>72</u> to <u>4/24</u> 19 <u>72</u> that (1) (we) last saw the deceased alive on <u>4/24</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>James Franklin Grim MD</u>			23B. DATE SIGNED <u>4/24/72</u>		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>
23C. PHYSICIAN'S NAME (Type) <u>James Franklin Grim MD</u>			23D. ADDRESS <u>Johns Hopkins Hospital</u>		
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>4-29-72</u>		24C. NAME OF CEMETERY OR CREMATORY <u>CHURCH Cem.</u>	
24D. LOCATION (City, town, or county) <u>BALTO., Md.</u>		24E. STATE <u>Md.</u>			
25A. DATE REC'D BY HEALTH DEPT. <u>APR 26 1972</u>		25B. NAME OF REGISTRAR <u>Edson A.H.</u>		25C. FUNERAL DIRECTOR <u>V. BAILEY</u>	
25D. ADDRESS <u>1348 CALHOUN ST.</u>					

11 000-11